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LEADERSHIP AND MANAGEMENT
OF MEDICAL TREATMENT FACILITIES:
CASE STUDY OF CHARLESTON NAVAL HOSPITAL,
1988-1993

by

Douglas H. Fairfield

June, 1993

Thesis Advisor: Professor James Edward Suchan

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Leadership and Management
of Medical Treatment Facilities:
Case Study of Charleston Naval Hospital,
1988-1993

by

Douglas H. Fairfield
Captain, United States Marine Corps
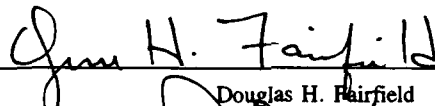B.S., North Carolina State University

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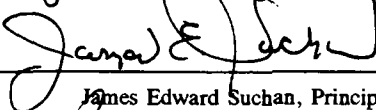of the requirements for the degree of

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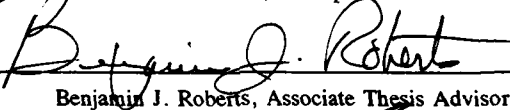June 1993
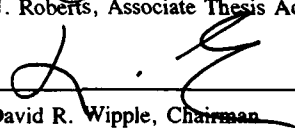
Author: _____
Douglas H. Fairfield

Approved by: _____
James Edward Suchan, Principal Thesis Advisor

_____
Benjamin J. Roberts, Associate Thesis Advisor

_____
David R. Wipple, Chairman
Department of Administrative Sciences

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ABSTRACT

This thesis is a series of case studies that explore a wide variety of management issues and problems encountered in a Navy medical treatment facility. Management issues covered include: decision making and problem solving, creating and communicating a vision, managing change, empowering subordinates, implementing Total Quality Leadership, conflict management, and leadership during times of crisis and uncertainty. The cases are based on events that occurred at the Charleston Naval Hospital between 1988 and 1993.

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I. INTRODUCTION

A. GENERAL DESCRIPTION

This thesis explores leadership and management issues faced at the Naval Hospital, Charleston, South Carolina from 1988 to 1993. The information is presented in case format to facilitate the teaching of management topics to prospective military medical treatment facility (MTF) leaders. Specific management issues covered in the case include creating and communicating a vision, managing change, building effective teams of subordinate leaders, empowering subordinate leaders, using Total Quality Leadership (TQL) techniques, and improving communications in the organization.

B. BACKGROUND

Section 8096 of the FY 1992 Defense Appropriations Act stated that, "None of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a health care professional unless the prospective candidate can demonstrate professional administrative skills." [Ref. 1] To meet this mandate set by Congress, the Bureau of Navy Medicine and Surgery (BUMED) entered a partnership with the Naval Postgraduate School (NPS) to first find out what management skills were needed to manage

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Navy MTFs and then form an executive management education program to develop those skills.

To determine the management education needs in Navy MTFs, the Administrative Sciences Department of NPS surveyed 720 Navy medical leaders. The survey determined that communication, decision making/problem solving, organizational behavior, manpower and human resource management, and financial management were the most needed skills by leaders of Navy MTFs.

In addition to the survey, faculty members in the Administrative Sciences Department, NPS, formed liaison relations with several Navy MTFs in 1992 and 1993 to better understand the particular needs of each facility. During a liaison visit to Charleston Naval Hospital, NPS faculty were impressed by the management and leadership of the MTF, particularly by the command's vision, its willingness to empower its workers, and the enthusiasm of MTF leaders and staff. Based on the favorable liaison visit and the belief that management lessons from Charleston would benefit other MTFs, the case presented in this thesis was proposed for use in management education modules to educate prospective MTF commanders.

Naval Hospital Charleston is also unique among Navy MTFs in that it has served as the Navy's Catchment Area Management (CAM) demonstration site since 1988. As the CAM demonstration site, Charleston Naval Hospital is leading the Navy's efforts

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in its transition to coordinated care. Additionally, Charleston Naval Hospital contains one of the four Navy residency programs for family practice training. The added management challenges incurred by the CAM demonstration and residency programs contributed to the selection of Charleston Naval Hospital for use as a management education case.

The years 1988 through 1993 were chosen for the case since a variety of management challenges occurred at Charleston Naval Hospital during the period. Besides the CAM demonstration project, the hospital had three commanding officers, experienced the tragedy of hurricane Hugo, mobilized for Operations DESERT SHIELD and DESERT STORM, and received notice that the hospital faced closure as part of military downsizing.

C. RESEARCH QUESTIONS

The primary research question addresses what appropriate leadership styles and actions are necessary to effectively lead and manage military MTFs. Secondary research questions address managing change and uncertainty caused by military downsizing and health care cost containment. Included in the secondary research question is the management of change and uncertainty caused by the transition to coordinated medical care.

D. SCOPE, LIMITATIONS, AND ASSUMPTIONS

Efforts were made to present the information contained in the case accurately. However, the case was written primarily for use in management education modules for MTF leaders. To enhance the case as a teaching tool, certain events in the case were emphasized to highlight specific management issues. Additionally, the case was based on data gathered primarily from interviews of MTF personnel. The use of multiple interview sources was used extensively to avoid the effects of personal bias and opinion likely to occur in individual interviews. Whenever possible, documentation was used to verify events and dates. Finally, all names used in the case are fictitious.

While the case specifically focuses on the Charleston Naval Hospital and its leadership, the management issues covered are germane to other Navy MTFs. These issues and the leadership challenges they pose are especially relevant because of the Navy's transition to coordinated care, the current focus on health care cost containment, and the ongoing military downsizing. These issues are highlighted by Charleston Naval Hospital's experience with CAM and its inclusion on the 1992 military base closing list.

The target audience for the case and proposed management education modules are MTF directors and department heads. No prior management education training of the target audience is assumed for the case's use. However, a greater understanding

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of the management issues presented and livelier group discussion would be expected from students with prior management education and experience.

E. ORGANIZATION OF THESIS

Four chapters follow this introductory chapter. Chapter II discusses the case methodology and the process used to gather data. Chapter III contains the management case which is separated into four sections, each of which highlights different management areas. Case section one covers problem solving, interpersonal relations, and crisis management topics. Case section two covers the setting of standards and transitional management issues. Case section three covers a variety of management issues including, creating and communication a vision, and employing TQL techniques. Case section four covers empowerment, professional education, communication, and managing change issues.

A summary and analysis of major themes follow in Chapter IV. Chapter V contains a summary statement that addresses the primary and secondary research questions. Chapter V ends with suggestions for further research.

II. CASE METHODOLOGY

A. INTRODUCTION

Personal interviews, group discussions, internal memorandums and directives, external reports, and news media provided data for the case. The data collection process consisted of three stages: site selection and interview question research, interviews with MTF staff, and follow-up research. The goal of using multiple data sources gathered over time was to improve the accuracy and reliability of the case.

B. SITE SELECTION AND INTERVIEW QUESTION RESEARCH

1. Site Selection for Case

Faculty from the Administrative Sciences Department, NPS, initially visited Charleston Naval Hospital in June 1992. During the visit, the faculty established liaison and conducted informal interviews with the MTF staff and leadership. From the visit, the faculty were impressed by the command's vision, its willingness to empower its workers, and the enthusiasm of MTF leaders and staff. Furthermore, the command's use of TQL techniques and management teams as well as its ability to manage change impressed the faculty during their initial visit. The faculty left Charleston Naval

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Hospital feeling that the MTF was an outstanding organization that was well led.

Because of this initial visit, the NPS BUMED project faculty decided that a management case of Charleston Naval Hospital would make an interesting and valuable case for use in BUMED sponsored management education modules. Additionally, Charleston Naval Hospital's role as the Navy's CAM demonstration site gave further reason to use the MTF as a basis for a management case.

2. Interview Question Research

Questions asked during data gathering interviews with Charleston MTF staff were influenced by three sources: the initial Charleston Naval Hospital faculty visit, a NPS fielded survey, and background information from the current literature. The three sources provided background information necessary to generate questions that were both specific to the Charleston MTF and relevant for the case. The initial faculty visit provided a general overview of the organization and introduced key MTF leaders. The survey and review of the current literature provided additional background information and provided information on topics relevant to Navy medical leaders in general.

The survey titled, "Managing a Military Treatment Facility: A Survey of Educational Needs," performed by the Administrative Sciences Department, NPS, influenced interview

questions by highlighting management areas of importance to Navy MTF leaders. The survey's purpose was to determine what management areas were most important in administering a Navy MTF. The survey also determined what additional management education would benefit MTF leaders. Appendix A contains a copy of the survey.

The survey recipients ranked management education areas needed from highest to lowest in importance as follows: 1) communication skills; 2) decision making/problem solving; 3) organizational behavior; 4) manpower and human resource management; 5) financial management; 6) program planning and evaluation; 7) legal issues; and 8) operation management training. The recipients considered all management topics included in the survey important. Questions used during interviews with Charleston MTF leaders and staff included many of the above topics.

The survey was sent to 720 top Navy medical administrators which included:

- All COs, XOs, OICs, and directors of Navy hospitals, medical clinics, dental centers, dental clinics, and me lical/dental specialized commands

- Operational force key executives of the Naval Fleet, Fleet Marine Forces, and Fleet Hospitals

- Key executives of navy medical headquarters commands

- A total of 44 Medical Corps officers, 269 Medical Service Corps officers, 71 Nurse Corps officers, 124 Dental Corps officers, two Supply Corps officers, six civilians, and two senior enlisted sailors

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- All officers screened for executive officer and commanding officer of MTFs.

In addition to the survey and initial faculty visit, background information for questions was obtained through the current literature. The literature review had two purposes: to become familiar with the Charleston Naval Hospital and the health care industry and to provided insight and understanding of health care issues so that researchers could ask germane questions when interviewing MTF leaders and staff. The literature review also provided information for the background section of the case.

C. PERSONAL INTERVIEWS

Most of the data for the case was obtained through interviews of leaders and staff of the Charleston Naval Hospital during a three-day visit in January 1993. Personnel interviewed included the commanding officer, executive officer, all the MTF directors, and a sampling of staff members at lower levels of the MTF. The concentration of interviews at the top management levels of the MTF was intentional since the case is directed at director and department head level personnel. The purpose of interviewing those at lower levels of the organization was to determine how upper managements decisions affected the MTF at all levels.

For the most part, interview questions focused on management and leadership issues in the MTF. Core sets of

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questions prepared in advance were augmented by follow up questions generated during the interviews. Except for the initial interview with the MTF commanding officer, questions covered in the interview were not provided to the interviewees in advance. Each interview, except for the commanding officer, lasted approximately one hour. The interview with the commanding officer lasted approximately three hours. A list of core questions used in interviews with the MTF commanding and executive officers is included in Appendix B.

Prior to conducting personal interviews of MTF staff members, a group discussion was held with the MTF directors. This discussion focused on the survey results and provided an open forum to discuss specific management issues at the Charleston Naval Hospital. The group discussion validated the importance of the management areas covered in the survey and in the interview questions to directors at a typical Navy MTF. The group discussion also provided a general overview of the organization, provided a forum for introduction, and provided information for follow-up interviews.

Personal interviews with MTF staff and leaders followed the group discussion. Interviews with the commanding officer, executive officer, and all MTF directors were specifically requested. All other interviews were requested by billet type. The billet requests were then filled by individuals selected by the MTF front office. The billets requested were selected to give as diverse a view of the organization as

possible given interview time constraints. A summary of those interviewed at the MTF included:

- The commanding officer
- The executive officer
- All MTF directors
- Three department heads (one physician, one clinical non-physician, one administrative)
- One clinical nurse
- One enlisted medical technician
- One clerical civil servant employee
- One contract physician
- The CAMS project officer and assistant.

Two person teams conducted the personal interviews where one interviewer asked questions and one took notes. The interview teams consisted of combinations of myself and three faculty members from the Administrative Science Department, NPS. The pairing of the interview partners changed from interview to interview based on personal interests and time constraints.

The interviews were not tape recorded so as to encourage open discussion. After each interview, the two interviewers discussed the interview to ensure consistency, completeness, and to limit individual bias. After all the interviews were completed, the interview teams combined notes and discussed the interviews to clarify any ambiguous points.

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D. FOLLOW-UP RESEARCH

Follow-up telephone interviews and documentation collection augmented, clarified, and substantiated information gathered in personal interviews. The follow-up telephone interviews were made with individuals both inside and outside the Charleston Naval Hospital organization, including past MTF commanding officers and administrators from other military health organizations. Documentation collected included:

- The Charleston Naval Hospital Organizational Manual
- Unit award recommendations
- Internal memos and directives
- Command histories
- CAM background data
- Unit training program documentation
- Public affairs newsletters.

A faculty visit in March 1993 to naval hospitals in Orlando and Jacksonville, Florida further validated the need for management education in the areas specified in the management education needs survey. Also during the visits, MTF leaders expressed interest in receiving future in-house management education from NPS staff.

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III. CASE STUDIES

A. INTRODUCTION

Charleston Naval Hospital is classified as an echelon IV medical treatment facility (MTF) as are similar naval hospitals throughout the world. The primary role of naval hospitals is to provide health care to active duty Navy and Marine Corps personnel so that they may carry out their missions. Because of their primary mission, active duty military personnel receive priority of treatment. If space and resources permit, care is also provided to retirees and to dependents of active duty members and retirees. Finally, federal civilian employees injured on the job may receive treatment.

The activities performed by Navy MTFs include health promotion, care and treatment of the sick and injured, health care education for the fleet, mission-related medical research, and prevention and control of disease. In addition, Naval hospitals perform a vast array of other relevant tasks including training Navy medical personnel, disaster relief, community relations, and other tasks approved by the Bureau of Medicine and Surgery (BUMED).

Leaders of Navy MTFs plan, execute, and evaluate the many programs required to accomplish their mission. In doing so

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they must conform to health care industry standards and to military regulations. Additionally, they must lead and coordinate the efforts of diverse military and civilian personnel. Finally, they must ensure the quality and cost effectiveness of the health care provided.

Charleston Naval Hospital's leadership faced many challenges as they provided health care to the Charleston area. Those challenges were compounded by uncertainties caused by shrinking military budgets, force reductions, and military base closures. MTF leaders also faced health care costs inflation and related problems associated with the health care crisis in the United States. Charleston Naval Hospital's leadership also faced the challenge of putting together and administering a unique health care provider network as part of the Navy's Catchment Area Management (CAM) demonstration project.

Charleston Naval Hospital has provided exceptional health care at its current site since 1973. However, since 1988 the MTF leadership has had to overcome many internal personnel and management challenges to improve quality care and service at the facility. Additionally, MTF leaders have had to deal with many outside contingencies such as Hurricane Hugo, Operations DESERT SHIELD and DESERT STORM, and the MTF's selection as a Catchment Area Management demonstration project.

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B. BACKGROUND

Roots of a naval hospital in Charleston date back to 1906 when hospital tents housed the medical department at the Charleston Navy Yard. In 1917, the Charleston Naval Hospital was officially commissioned and was located in 19 temporary wooden buildings with a capacity of 250 beds. Through the years the hospital occupied two other facilities before completion of its latest building in 1973.

In addition to the core hospital site, the Charleston Naval Hospital Command includes branch medical clinics at the Charleston Naval Base, Naval Shipyard, and Naval Weapons Station. The naval hospital command is also responsible for coordinating the various shore based naval medical facilities and programs available to the Charleston community.

Charleston Naval Hospital is among the largest of the Navy's community hospitals, serving approximately 103,000 persons in the Charleston, South Carolina catchment area. As of 1992, the hospital had 181 beds with a staff of over 1200 personnel. In 1992, the hospital staff treated approximately 365,000 patients in outpatient clinics. Additionally, the hospital admitted over 9,000 patients, performed over 3,000 surgeries, and delivered over 1,300 babies.

Charleston Naval Hospital served as the Navy's only Catchment Area Management (CAM) demonstration site which became operational in January 1990. The purpose of CAM was to control health care cost growth and to improve the quality

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of care through the use of a network of providers in a forty-mile radius catchment area. The CAM demonstration required MTF leaders to set up and manage a CHAMPUS health care provider network. MTF leaders were also responsible for both the MTF operating budget and the CHAMPUS budget within the catchment area. Improved quality and reduced cost growth were to be realized through better coordination of direct care and CHAMPUS assets, and through discounts contracted with network providers.

Charleston Naval Hospital is also one of five Naval hospitals sponsoring a residency program to train family practice Navy medical doctors. The residency program brings research talent into the organization and allows the MTF to accept a greater diversity of medical cases in order to train the residents. The residency program also enables the MTF to form partnerships with the local Medical University of South Carolina in Charleston. Overall, the residency program at Charleston is a source of pride for the MTF since it adds a level of uniqueness and professionalism that is absent in most community hospitals which lack residency programs.

MTF Chain of Command.

Since a BUMED reorganization in 1989, echelon IV MTFs have a dual chain of command. Operationally, Navy MTF's come under the command of a regional line commander (RLC). Administratively, Naval hospitals report to BUMED through one

of four Healthcare Support Offices (HSO). The RLC for Charleston Naval Hospital is the Commander of the Naval Base in Charleston. The HSO for Charleston Naval Hospital is located in Jacksonville, Florida.

MTF's come under the operational control of the RLC in order to provide better support to the fleet. However, almost all operating resources, technical assistance, and management information system support comes from BUMED through the HSOs. As a result of the structure, MTF commanding officers must deal with conflicts and competing priorities inherent with the dual chain of command. A diagram of a typical Navy MTF's chain of command is found in Appendix C.

Since its commission in 1917, the Charleston Naval Hospital has been commanded by a succession of Navy captains. The MTF commanding officer (CO) is directly responsible to the RLC and HSO for all medical care provided in the hospital, the meeting of budgets, and all MTF staff. In addition to the internal leadership of the hospital, the MTF CO forms external liaisons with senior navy medical and operational commanders, civilian health care providers, and local community leaders.

Organizational Structure.

The standard Charleston MTF organizational structure is shown in Appendix D. In addition to the normal special assistants and headquarters staff, seven directors of key MTF

functional areas report to the CO of the Charleston Naval Hospital. The directors include:

- Director for Administration (Code 01)
- Director for Nursing Services (Code 02)
- Director for Medical Services (Code 03)
- Director for Surgical Services (Code 04)
- Director for Ancillary Service (Code 05)
- Director for Occupational Health and Preventative Medicine (Code 06)
- Director for Strategic Planning (Code 07)

The organizational structure of the Charleston Naval Hospital is typical of other Navy MTF's except for the Strategic Planning Directorate. The Director for Strategic Planning (DSP) did not exist prior to 1991 and was added to better manage the CAM demonstration. A description of the key directorates of the MTF is included in Appendix E.

Collectively, the major functional directorates formed the MTF board of directors. Since 1988, the MTF board of directors met daily to discuss hospital policy and other issues of mutual interest. The board also served as intermediaries between the CO and XO and the MTF departments under each directorate. In addition to the board of directors, thirty-two standing committees assisted the CO in maintaining standards for graduate training and accreditation, in conforming to legal requirements, and in providing additional advice on matters of policy and special interest.

A description of duties of the standing committees is found in Appendix F.

For the MTF to run efficiently, directorates must cooperate since each depends on the others for services. Factors affecting cooperation between directorates include staff shortages; differing priorities between directorates; institutional biases between physicians, nurses, and medical service corps personnel; and individual egos. Furthermore, cooperation among directorates is essential because of the need to set budget priorities and distribute scarce dollar resources. Without cooperation, decisions concerning equipment purchases, types of treatments to perform in the MTF, training and travel needs, and hiring of civilian personnel could not be made by the directors.

C. CASE ONE: A NEW COMMANDING OFFICER ARRIVES

In July 1988, Captain Hendrix assumed command of the Charleston Naval Hospital. He found that shortages of staff and resources resulted in constant turf battles between the directorates. Cooperation between directors was nearly nonexistent. Additionally, he learned that the previous CO and XO displayed favoritism to certain directorates creating animosity within the board. In many cases, professional issues between the directorates became personal ones.

Eventually, the lack of coordination and distrust filtered to lower levels of the organization. Many in the MTF felt

that little direction was being provided from the top. Without unified leadership, standards were not consistently set and enforced, planning was ineffective, and morale was low. A recent suicide of a well-liked physician in the MTF further caused morale to plummet. The MTF was in a state of turmoil. Without a change, the internal problems of the MTF would adversely affect the quality of care provided.

Additionally, two other problems required Captain Hendrix's attention:

1. Many in the MTF believed that they were being discriminated against on the job. They felt as though the discrimination prevented them from receiving fair treatment for promotion and in evaluations. Moreover, they felt that no action was being taken on their complaints from their supervisors or anyone else in the chain-of-command.

2. The high-visibility CAM demonstration project was just getting underway. Since the project was new, much uncertainty existed throughout the MTF on what effects the project would have on the organization. To complicate the issue, the CAM project officer was unwilling to work closely with the MTF CO, even though the MTF CO was responsible for the program.

The equal opportunity problem was particularly damaging to the organization since the issue was politically sensitive and invoked strong emotions among MTF personnel. As a result, morale within the organization sank. Prior to Captain Hendrix's arrival, the equal opportunity/discrimination problem was more or less ignored by MTF leaders until allegations of discrimination were brought to the attention of the naval base commander. The failure of MTF leaders to act quickly and decisively to correct the problem caused many MTF

staff members to question the effectiveness of the MTF leadership and its ability to address important issues.

Problems associated with the CAM demonstration were also important to the MTF and the new commanding officer. The CAM project created uncertainty largely because of the program's newness and uniqueness. Charleston Naval Hospital was the only CAM demonstration site selected by BUMED. As the sole demonstration site, great expectations for the program's success were placed on the MTF.

BUMED designated a project officer to lead the CAM effort from the onset of the demonstration. The project officer, Captain Young, was a former CO of Charleston Naval Hospital. As CAM project officer, Captain Young was now tasked to report to the new MTF CO. Understandably, Captain Young was reluctant to report to the MTF CO who was his junior and was filling the position he once had. Moreover, due to his selection by BUMED, Captain Young was able to circumvent the MTF and report directly to BUMED without repercussion.

Captain Young was tasked to develop a network of health care providers contracted to provide service to CHAMPUS users at reduced rates. He was also tasked with developing the CAM program specifics in a way to meet the demonstration's objectives. Those objectives included improving beneficiary satisfaction, enhancing the military practice environment, assuring clinically appropriate cost effective services, and containing CHAMPUS inflation. Captain Young's tasks were

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particularly important since the CAM program would not be authorized by BUMED to operate until the provider network was set up and program specifics were finalized. Cooperation between the MTF, the Catchment Area Management Systems (CAMS) office, and civilian providers was essential in developing the network.

Cooperation between Captain Young's office and Captain Hendrix's was also critical since Captain Hendrix would be responsible for managing all Navy MTF and CHAMPUS health care expenditures within the Charleston catchment area. To do this well, Captain Hendrix would require CHAMPUS cost data from the CAMS office. The cost data was critical since the CO was responsible for CHAMPUS expenditures while BUMED retained control of CHAMPUS funds. With such a system, the MTF CO could not simply redirect CHAMPUS funds to direct care, even if a net savings would result.

Data from the CAMS office would enable the MTF CO to determine how to best integrate MTF and provider network capabilities. To control costs, he could direct beneficiaries to use the most cost effective provider, whether at the MTF or through a network physician. With close coordination between the CAMS office and the MTF, procedures that could best be performed at the MTF could be readily identified. Similarly, procedures that could best be treated by a network provider could easily be identified and treated using CHAMPUS.

Despite the need for cooperation, Captain Young was determined to develop the CAM program on his own. Moreover, it was evident to Captain Hendrix that Captain Young's attitude would not change. To Captain Young, CAM was his responsibility, not Captain Hendrix's.

CASE QUESTIONS:

1. Given the situation at the MTF when Captain Hendrix assumed command, what problems do you feel are most serious? How would you prioritize them? Why?

2. At this point, what would you do if you were Captain Hendrix?

3. How would you handle your relationship with Captain Young?

Captain Hendrix.

Captain Hendrix's reputation as an outstanding clinician and leader preceded his arrival as the new MTF commanding officer. In his younger days, he competed as an Olympic-class athlete. Even though he was in his late forties, his physical appearance still commanded respect. He carried himself with confidence, and when he entered a room, everyone immediately felt his presence. He was in charge and people knew it.

As the new commanding officer, Captain Hendrix immediately realized that he needed to restore confidence in the MTF's leadership. The hands-off leadership style of the past CO created an environment where small issues grew into large problems. The combination of poor director coordination, staff shortages, equal opportunity problems, and a tragic

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suicide had created turmoil within the MTF. Captain Hendrix realized that the best way to bring about change was to address each problem directly and forcefully.

At every opportunity, Captain Hendrix proclaimed that he was sent to command the MTF to correct its problems. His message was spread throughout the MTF through the chain-of-command, through Captain's Calls, and through personal contact with MTF personnel. When addressing the equal opportunity problem, he clearly stated that anyone found discriminating against another would be punished quickly and severely. He made it clear that, under no uncertain terms, discrimination would not be tolerated at the MTF. Everyone in the MTF understood the policy. Moreover, everyone knew that Captain Hendrix would carry out his threats of punishment to guilty parties. In addition to the clear communication of policy, awareness and training of the issue was conducted with all MTF staff through Captain's Calls and through programs set up by the equal opportunity office. Before long, the perception of discrimination in promotion and evaluation was not an issue at the MTF.

Captain Hendrix took similar action to get the board of directors to work together. He demanded professionalism by the MTF directors and received it. By presiding over the director's meeting each morning, he forced the directors to cooperate with one another and to improve communications between each other. When resolving problems he quickly made

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decisions, let his subordinates know what was expected, and demanded results. Getting to the core of problems and taking action were more important to him than time-consuming analyses of details or letting the directors sort out the problems on their own.

The amount of decision making authority Captain Hendrix gave each director depended upon his judgement of their abilities. He kept abreast of each directorate through his presence at the daily meetings. It was not uncommon for Captain Hendrix to tell directors how to conduct their business. Additionally, because of his people-oriented direct approach, Captain Hendrix would bypass the directors by going to the department heads to obtain information.

Captain Hendrix's presence was felt throughout the MTF. He regularly visited all areas of the MTF to see how the staff and patients were doing. When visiting patients he exhibited genuine concern for their well-being. His personality put people in the various hospital wards at ease. To many in the MTF, he was a father figure.

The situation with Captain Young created a different set of problems for Captain Hendrix. Due to Captain Young's position, Captain Hendrix could not realistically control the CAMS office as he could the MTF. Attempting to issue direct commands to Captain Young would further alienate the CAMS office. Therefore, Captain Hendrix let Captain Young run the CAMS office as he saw fit. With such an arrangement,

coordination between the CAMS office and the MTF was less than optimum. However, Captain Hendrix believed that this arrangement was better than total isolation between the two.

Case Questions.

1. Do you think that Captain Hendrix did the right things to solve the MTF's problems? What are the benefits and limitations of using a top-down leadership approach?

2. Do you think that Captain Hendrix used the correct approach in dealing with his directors? What could he have done differently?

3. Do leaders need personal charisma and command presence to be effective?

4. Do you think that Captain Hendrix handled the relationship with Captain Young appropriately? What other approaches could Captain Hendrix have taken?

Problems With JCAHO.

Before long, confidence in the MTF leadership was restored. Morale was improving and turmoil was decreasing. However, in January of 1989, the MTF faced an entirely new set of problems. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) conducted its scheduled survey and found major contingencies in all medical staff areas. In many cases record keeping was inadequate or nonexistent. Additionally, the JCAHO survey determined that the MTF's quality assurance program was ineffective. Discrepancies noted by the JCAHO included:

- Committees required by JCAHO existed but did not perform their designed duties. The Credentials Committee reviewed

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and made judgements on all cases where physicians performed outside the standards of care. Those decisions were the responsibility of the Executive Committee of the Medical Staff. For the most part, the Executive Committee of the Medical Staff was a token committee; it accomplished very little.

- The Peer Review Program sought to protect physicians rather than objectively evaluate cases. Incidents where physicians performed procedures outside the standards of care were not properly reviewed and documented. A general lack of understanding of the peer review program by those involved contributed to the program's ineffectiveness.

- The Accreditation Committee and Quality Improvement Committees, which were responsible for keeping the medical staff informed of accreditation requirements, did not fulfill their obligations. As a result, clinicians did not receive training on accreditation requirements.

- The clinicians were not aware of what documentation was required for accreditation. Committee staff members tasked to train the clinicians were not aware of the clinicians' needs. There were no physician advisors on the quality improvement staff or on the accreditation committee.

- The quality improvement office was headed by an individual who had little interest in the job. The individual was largely ineffective and seemed more concerned about her approaching military retirement. As a result, quality assurance tended to be reactionary in nature vice proactive.

Although much progress had been made at the MTF since Captain Hendrix assumed command, the JCAHO survey findings showed Captain Hendrix that more work was needed to get the required committees to perform as intended, to improve communications within the MTF, and to conduct necessary training. As before, he intended to correct these new problems quickly.

However, Captain Hendrix also realized that correcting the JCAHO deficiencies required changes in the way the medical

staff and the accreditation committees conducted business. Changes were also needed to ensure MTF staff members were aware of what was required by the JCAHO. To compound the problem, it appeared that no one in the organization was quite sure of how to make the changes. Incorrect procedures had been in effect so long that they had become institutionalized. Similarly, the ineffective peer review process and the activities of JCAHO required committees were assumed to be correct by those participating.

Quality assurance (QA) was always important within the MTF. However, QA programs were limited to clinical areas and to patient care. Even then, the effectiveness of the programs were undermined by problems with the physician peer review system. In the medical staff areas, which included medical records, surgical and invasive procedures, blood usage, drug usage, and pharmacy and therapeutic, QA was non-existent. Poor documentation prevented those in the medical staff areas from effectively monitoring and evaluating their operations.

For the most part, quality within the MTF depended solely on the individual skills of the physicians and staff. The reliance on individuals for quality was an unavoidable and desired characteristic of health care as epitomized by the physician/patient relationship. However, quality assurance programs were important to ensure consistent quality and to set standards. At Charleston Naval Hospital, the programs to

monitor and to improve quality and consistency left much to be desired.

Since the MTF operated so long without standardized QA procedures, many believed that they were not really necessary. They felt that the programs require by the JCAHO would simply increase the workload without providing any additional benefit. Resistance to the changes would be considerable, especially since many did not know what JCAHO expected. To many, the requirements set by the JCAHO seemed ambiguous.

After evaluating the situation, Captain Hendrix developed his plan for change in order to correct the JCAHO discrepancies.

Case Questions:

1. How should Captain Hendrix go about making changes within the MTF to correct the JCAHO discrepancies? Who should be involved in the changes? Should Captain Hendrix use the same leadership and decision-making style he used to deal with the equal opportunity/discrimination issue?

2. How should the changes be communicated? What media should be used? Why?

3. What steps can be taken to make change easier to accept?

QA Becomes an Issue.

Captain Hendrix tackled the JCAHO discrepancies much like he tackled the MTF's previous problems. He clearly stated his expectations that the problems were to be corrected. As before, the MTF directors and department heads responded favorably. Problems highlighted by the JCAHO were faced

directly by the committees and the medical staff and were solved one by one. Progress was monitored by Captain Hendrix through the directors, through the accreditation committees, and through direct contact with MTF staff members who were affected by the changes.

One key change Captain Hendrix made was the hiring of a civilian to head the quality assurance office. This strategy proved valuable since many in the MTF were entrenched in their old, incorrect methods. The new QA coordinator, an outsider with experience in civilian hospital quality assurance programs, was able to bring new ideas and enthusiasm for quality programming into the MTF. The new quality assurance coordinator reported directly to the MTF's executive officer.

Under the direction of the new QA director, required accreditation committees were realigned so they performed their correct functions. Members of the committees were also trained so they knew what responsibilities they were required to perform. Perhaps most important, education of key MTF staff members in the areas of quality assurance and JCAHO requirements increased the awareness of quality assurance throughout the MTF. Such training consisted of one-on-one sessions with key MTF department heads as well as weekly scheduled group training.

Although most of the changes were brought about by direction provided from the quality assurance office, the changes would not have occurred without the full support from

Captain Hendrix. Since the changes were a priority of Captain Hendrix, they became a priority of the entire MTF. Before long, the JCAHO discrepancies were corrected. The commitment from the top, the education process, and the enthusiasm and ideas from a newly hired QA coordinator brought about the change despite anticipated resistance.

Hurricane Hugo.

On September 21, 1989 Hurricane Hugo hit the South Carolina Coast with full fury. The city and outlying areas of Charleston were devastated. The storm destroyed homes and property, took human life, and created havoc among those who survived. Homes and plantations from the Civil War era suffered extensive damage. Parts of the city lost electric power for over a week. Business were closed from storm damage; some never reopened. The storm forever changed the way Charleston looked. The people that survived were thankful to be alive.

Weather forecasters predicted two days in advance that the storm could hit the South Carolina Coast. Forecasters recommended that residents and businesses take action to prepare for the storm. Many in Charleston took action by boarding up windows, stocking up emergency supplies, and in some cases, leaving the area. Others simply ignored the warnings since they believed that the forecasters were overreacting.

Case Questions:

1. What actions should the MTF take to prepare for the coming hurricane? Should they prepare for a worst case scenario, take minimal precautions, or conduct business as normal?

2. In this case, what role should the CO take in mobilizing the MTF into action? Is the importance of strong leadership greater in times of emergencies? Why or why not?

3. What factors should Captain Hendrix take into account when deciding on what actions to take?

4. Do you think Captain Hendrix's past leadership style and the expectations of the staff created by the style would be helpful or a hinderance in dealing with Hugo?

Mission Accomplished

Despite the negative effects of Hugo, the storm brought the staff of Charleston Naval hospital together. After the storm, the environment in the hospital was compared to a field hospital during wartime. Throughout the ordeal, the MTF staff improvised to provide services despite the hardships placed upon them. Through adversity, the MTF staff pulled together and accomplished their mission. They performed admirably and had reason to be proud.

With only auxiliary generators providing power, the MTF provided emergency care to the Charleston community. The MTF was one of the few medical facilities in the area that remained in service. Patients from the nearby VA hospital and local nursing homes were treated when they could not receive

treatment elsewhere. The doors to the MTF were open to anyone who needed emergency care.

The MTF was able to perform its mission because it was prepared. Once receiving warning of the pending disaster, Captain Hendrix acted quickly. He gathered all directors and instructed them to have all hospital wards prepared for a worst case scenario. Additionally, he directed that the MTF be fully manned and ready to accept large numbers of storm victims. Finally, he instructed that spaces in the MTF be set up for families of MTF staff to stay when the storm hit. In essence, the MTF was a safe haven for families during the storm. With families safe inside the MTF, the staff could perform their jobs knowing their families were protected.

Once issuing the orders for preparation, Captain Hendrix kept abreast of the progress and gave additional guidance when necessary. He monitored the progress through reports from his XO, his directors, and through personal inspection of the hospital wards. A sense of urgency was felt throughout the MTF. Captain Hendrix was in charge; his presence was felt throughout the MTF. By the time Hugo hit Charleston, the MTF was prepared for the worst.

After the storm hit the coast, Charleston was relieved that the number of casualties did not reach the catastrophic numbers they feared. However, people were killed and injured and property damage was severe. The MTF had to rely on emergency generators for power for nearly a week. The

generators provided only enough power to keep emergency services available. Lights were out in many parts of the hospital, elevators were not operational, and the air condition system was shut down. All administrative functions and non-critical services were curtailed. The MTF was hot and humid, and the lack of power in parts of the MTF made the simplest of tasks difficult. Nevertheless, MTF staff members were happy because they were accomplishing their mission and doing their job when others in the area could not.

CASE QUESTIONS:

1. How did the external crisis play to Captain Hendrix's personal leadership style? Would other leadership styles be equally effective?

2. In the case of Hurricane Hugo, the crisis brought the MTF together. What would have caused differing results?

3. How do you think the MTF would have responded to Hugo before Captain Hendrix's command?

D. CASE TWO: SLOWLY BEFORE THE "STORM"

By June 1990, much had been accomplished under Captain Hendrix's tenure as CO. Morale in the MTF was restored. The problems with equal opportunity were resolved. The CAM network was in place and final approval was given by BUMED to begin the demonstration the prior January. Perhaps most importantly, confidence in the MTF's leadership was restored.

Captain Hendrix was immensely popular and respected throughout the MTF. He was a leader, friend, father figure,

and an example for all to follow. His presence would be missed.

After a two day turnover and an emotional change-of-command ceremony, Captain Reed assumed command of the Charleston Naval Hospital. Captain Reed was aware of the accomplishments and popularity of Captain Hendrix. However, he was now in charge.

Captain Reed.

Captain Reed's selection as CO was unique since he was the first Medical Service Corps officer to command the Charleston Naval Hospital. Prior to assuming command, he earned respect in his field of epidemiology. Additionally, he held masters and doctorate degrees in Public Health with an emphasis on epidemiology, biostatistics, and public health care. Furthermore, he had a photographic memory and approached problems in a no-nonsense, businesslike fashion. Immediately prior to assuming command, he served as the executive officer at another MTF.

As with Captain Hendrix, Captain Reed's physical appearance commanded immediate respect. He towered over most with his six foot-five inch frame. His height and presence camouflaged his normally quiet demeanor. He was the consummate professional; he set tough standards and expected performance. He expected nothing less than impeccable ethical behavior and professional integrity.

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After a few months of observation, Captain Reed was generally pleased with the MTF. However, he believed a few problems required his attention. They included:

- The organization did not have a set of recognized standards and values. As a result, standards were low throughout the MTF.

- Below the CO level, everyone seemed to follow his/her own agenda. Although the directors seemed to cooperate with one another, they still did not work together as closely as they should.

- Although the CAM demonstration was officially underway, the program was not operating effectively. Coordination between the CAM office and the MTF continued to be less than optimum.

Case Questions:

1. How should Captain Reed establish his presence as the new MTF CO. Should he attempt to make immediate changes or continue business as normal?

2. How does the fact that Captain Reed followed a popular and effective CO effect your decision on what actions should be taken by the new CO?

Setting Standards.

Captain Reed decided to initially act slowly and observe the MTF before making any significant changes. His initial reaction was not to tamper with the successes brought about by Captain Hendrix. Instead of making quick and substantive changes, he took time to get to know the MTF and its people. He then decided to make some small, largely symbolic changes to make an initial impression on the MTF. The area he decided to first address was organizational standards and values.

Captain Reed believed the main reason standards were low was that they were not stressed consistently, and values were not emphasized. Rather, expectations were set for specific issues when problems were encountered as in the case of equal opportunity and discrimination. He believed that organizational standards were important to ensure the MTF's unity of purpose. Organizational values were also important since they encourage people to do what was right.

To raise standards and establish organizational values, Captain Reed used several forums to express his views and increase awareness. Such forums included director meetings, Captain's Calls, E-mail messages, orientation speeches, inspections, and Captain's Mast proceedings. In each forum, Captain Reed focused on standards and values in specific areas.

Areas in which Captain Reed expected higher standards included personal appearance, performance evaluation, and personal relations. Improvement in personal appearance of MTF staff occurred after a uniform inspection in which the staff unexpectedly failed. At the uniform inspection Captain Reed clearly let everyone know that the old standards were no longer acceptable. After the inspection, the MTF knew that Captain Reed was serious about raising standards in all areas, including personal appearance.

Similarly, Captain Reed believed that performance evaluations at the MTF, and Navy in general, were substandard.

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To correct the problem in the MTF, he clearly stated his expectations for fitness reports and officer performance standards by sending a memorandum to all officers. As a result of the memorandum, performance evaluations were taken seriously at the MTF. The emphasis placed on performance evaluations also helped clarify what professional standards were expected of the MTF staff. A copy of the fitness report memorandum is included in Appendix G.

Captain Reed constantly stressed that the MTF was in the people business. Consequently, respect towards patients and other MTF staff members was expected by all. For punishment at Captain's Mast he would have individuals charged with disrespect and insubordination read and write an essay on Dale Carnegie's book, *How to Win Friends and Influence People*. He also used the MTF's E-mail network, the chain of command, and orientation speeches to emphasize the importance of high standards in personal relation areas.

As Captain Reed expected, standards were raised and organizational values were established through clear communication of his expectations. He believed that most people welcomed the new standards and values since it gave them a framework in which they could operate. Moreover, Captain Reed's commitment to high standards and values was reinforced by personal example.

Case Questions:

1. What are the pros and cons of Captain Reed's strategy of making relatively small, symbolic changes initially as opposed to broad shifts in policy? Do you think that Captain Reed's approach was appropriate given the situation?

2. Do you think that Captain Reed used the correct approach to instill organizational standards and values in the MTF? What could he have done differently?

Developing Teamwork

After focusing on specific standards and values issues, Captain Reed addressed the problem of getting directors to operate as a team. The directors often seemed more concerned with protecting their own turf rather than fully cooperating. Reasons for the lack of teamwork included Captain Hendrix's top-down leadership style and the XO's personality. Directors expected the CO or XO to intervene when problems developed between directorates. However, when the XO intervened, he created dissension between the directorates. He pitted them against one another when resolving problems in order to create confusion and increase his personal power. With confusion and dissention between the directorates, the XO could easily manipulate the directors and force them to accept his views.

The XO's personality was worrisome for Captain Reed since he felt the XO resisted his initial efforts for improvement. The XO was entrenched with the old CO's command style and was unwilling to change. Additionally, Captain Reed felt that the XO was biased against having a Medical Service Corps officer

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as the MTF CO. The XO's bias created additional reason for the XO to create division among the directors to undermine Captain Reed's efforts.

To get the directors to operate as a team, Captain Reed first tried to change the way the XO operated through coaching and counseling. However, after repeated attempts to work with the XO, Captain Reed realized that he would not change and would continue to create problems for him until the XO rotated. Therefore, he began looking for ways to transfer the XO before his scheduled rotation date.

In the meantime, Captain Reed clearly stated to the XO and directors that he expected them to work as a team. He emphasized that the directors and the XO were to solve their differences on their own. In a move dramatically different from the past, he stopped attending the daily board of director meetings. By not attending the meetings, the directors were forced to solve their problems on their own without CO intervention.

Instead of the daily meetings, Captain Reed met with the directors each Friday morning. At the weekly meeting, he expected each director to discuss improvements from the previous week and report on the status of their directorates. In addition to the weekly meeting, Captain Reed kept abreast of each directorate through reports from the XO and the directors as needed.

Case Questions:

1. What could Captain Reed have done differently, if anything, to get the XO to change?

2. Do you think that COs and XOs should transfer together? What are the pros and cons of such an arrangement?

3. How does Captain Reed's strategy to force the directors to cooperate differ from that of Captain Hendrix's? What are the advantages and disadvantages of each approach?

4. What interim MTF function enabled Captain Reed to establish a team-based approach with the directors? Could Captain Hendrix have used the same approach given the MTF's situation?

CAM Demonstration.

The approval to begin the CAM demonstration project in January 1990 was greeted with fanfare and great expectation by the MTF staff. Talk about CAM's potential and how it would benefit the MTF could be heard throughout the MTF. Eight months into the demonstration, the talk about CAM's potential remained the same. Essentially, the CAM program was in place; however, it was not fully integrated into the operations of the MTF. The directors and department heads were not yet incorporating CAM data and services into their daily practices. As was the case during the planning stages of the demonstration, coordination between the CAMS office and the MTF's operations was less than optimal.

In addition to the internal coordination problems, Captain Young's abrasive personality created animosity toward the CAM

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program by several of the network providers. The network providers resented his arrogance and his inflexibility when conducting business with the CAMS office. Additionally, like the MTF XO, Captain Young did not believe that a Medical Service Corps Officer was qualified to command a Navy MTF. Because of his view, Captain Young voiced his disapproval of the CO to many of the network providers. As a result, some in the network expressed concern about their participation in the CAM program and the leadership at the MTF.

Captain Reed attempted to work with Captain Young to improve the CAM problems without much success. The situation looked bleak until Captain Young received unexpected orders overseas in late 1990. Furthermore, BUMED did not designate Captain Young's replacement. It was up to Captain Reed to fill the CAM vacancy with an MTF staff member.

Case Questions:

1. **What should Captain Reed do to capitalize on the sudden transfer of Captain Young? How can he use the opportunity to restore credibility in CAM and MTF leadership with the network providers? How can he use the opportunity to better coordinate CAMS with the MTF?**

2. **What factors should Captain Reed consider when replacing Captain Young? Who should be involved in the decision making process?**

Liaisons and Creating the Director For Strategic Planning

Once Captain Young transferred, Captain Reed seized the opportunity to get the CAM program on track. However, he did

not immediately fill the CAM project officer position. Instead, he personally took control of the program.

Initially, Captain Reed focused on improving the image of CAM and the MTF leadership to network providers. To do so he met with and developed rapport with the CEO's of all eleven of Charleston's civilian hospitals. He also met with other prominent health care providers in the area, as well as with community leaders. Through personal interaction, Captain Reed was able to dispel the unfavorable impressions left by Captain Young concerning CAM and the MTF leadership.

After meeting with the provider and community leaders, Captain Reed's staff in the CAMS office followed-up and took action on the problems raised. To ensure proper follow-up, Captain Reed monitored the progress of his subordinates closely. During this period, Captain Reed spent approximately sixty percent of his time working on the CAM project.

After he was satisfied that confidence was restored in the CAM program and the MTF's leadership, Captain Reed selected an officer to fill the CAM project officer position. To ensure continuity and expertise, he selected an officer who worked in the CAMS office.

Captain Reed wanted to improve coordination with CAM and the MTF by giving the project officer directorate status. However, he was aware that some of the directorates resisted formation of a new directorate. They feared loosing decision making authority to a CAM director backed with data. To help

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ease the fears, Captain Reed instructed his XO and directors to provide input and develop a plan to best coordinate the efforts of the CAMS office and the MTF.

After deliberation, the XO and directors recommended the creation of a new directorate as envisioned by the CO. The new directorate was given the title of "Director For Strategic Planning (DSP)." Over time, acceptance of the DSP by other MTF directors occurred as they discovered how data and a successful CAM program benefited their directorates.

Case Questions:

1. Do you think that Captain Reed took the right approach by not immediately filling the CAM project officer position? What would you have done differently?

2. What are the advantages of allowing subordinates to get involved with making decisions as Captain Reed did with the creation of the DSP? What are the disadvantages?

DESERT SHIELD

On August 2, 1990, Iraq surprised the world by invading and occupying Kuwait. In the months that followed, the United States deployed over 250,000 troops to defend Saudi Arabia in an operation that was later termed, "DESERT STORM." The speed and magnitude of the mobilization set new precedents. Active duty and reserve service members deployed half way around the world did not know if they would return in a month or a year. Saddam Hussain threatened to wage the "Mother of All Battles" against the coalition forces. Back in the United States, no one was sure what would happen next.

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Since no one was sure of the number of casualties to expect, preparations were made for a worst case scenario. The hospital ships USNS MERCY and USNS COMFORT were manned and deployed to the Persian Gulf. Similarly, MTFs of all services were required to make wartime preparations.

Charleston Naval Hospital was designated as one of three Department of Defense primary casualty receiving hospitals. To fulfill that obligation, the MTF was required to enlarge its bed capacity, establish liaison with MTFs of other services, and establish administrative procedures for transportation and tracking of patients from the Air Force Aeromedical Staging Facility. Additionally, the MTF was required to deploy 174 active duty personnel from the MTF to Southwest Asia, train reservists to replace deployed staff members, and screen the records of hundreds of reservist identified for possible deployment. The MTF had one month to complete the tasks, while still providing services to beneficiaries.

Captain Reed had been at the MTF only a few months prior to this point. His subordinates were aware of his emphasis on standards and his work with CAM. However, they were still unsure of his leadership abilities because he was still too new at the job for them to determine his true mettle. Moreover, the MTF had been running fairly smoothly; Captain Reed had yet to be tested.

Case Questions:

1. What role should Captain Reed play in preparing the MTF for DESERT SHIELD? Should his newness to the organization influence his actions?

2. How does the situation differ between what Captain Reed faces now and what Captain Hendrix faced just prior to Hurricane Hugo?

3. What other preparations could Captain Reed and the MTF make given their situation?

4. Does Captain Reed appear to be the right person for the job. Is there anything about his background, training, or mindset that would help him meet the challenge?

Preparing for the "STORM"

Captain Reed recognized his strengths and limitations, as well as those of his subordinates. Furthermore, with such a large task at hand, he realized the coordinated effort of everyone in the MTF would be required given the time constraints. Therefore, to prepare the MTF for DESERT SHIELD he delegated much authority to his subordinates. His subordinates were the experts in their areas, so they could best make the changes that were required. However, he was ultimately responsible for the actions of the MTF. To meet his responsibilities, he would provide direction and supervision to coordinate his subordinates' efforts.

One of Captain Reed's first decisions was to have his XO deploy to Southwest Asia. By transferring his XO, Captain Reed could provide direction to the MTF without the added burden of supervising an adversarial XO. Additionally, with

only a few weeks to prepare for possible incoming war casualties, Captain Reed did not have the time to worry about personality conflicts in the front office.

After a quick study of the situation, Captain Reed assembled his directors and developed plans for the MTF's preparation. The plans included:

- transforming administrative/clinical spaces on the fifth, sixth, and eighth floors of the MTF to patient beds

- developing liaisons with other MTFs and the USAF Aeronautical staging facility to ensure effective patient tracking

- preparing for the deployment of MTF staff members by screening records, providing immunizations, and providing administrative and legal support

- setting up training programs and providing administrative support for reservists called to active duty to fill vacancies created by deployed MTF staff

- providing administrative support and immunizations to deploying reservists

- developing a family support network for spouses of deployed MTF staff members through the chaplain's office.

After the meeting, everyone in the MTF went to work to meet the challenges. Coordinated efforts between the MTF staff and the naval base public works facility quickly expanded the MTF bed capacity by tearing down walls, replacing floor and ceiling tiles, and modifying electrical and plumbing fixtures in former administrative spaces. Staff members worked around the clock procuring additional medical supplies, blankets, and equipment to meet the required expansion.

Similarly, administrators and clinicians worked around the clock to inspect records, coordinate travel arrangements, and provide immunizations to deploying staff and reservists. In a four day period alone, the MTF verified 950 medical records and administered over 2000 immunizations to reservists deploying to the USNS MERCY and USNS COMFORT. After the initial rush, records of all other MTF staff members were screened in case further deployments were required.

Additional preparations included conducting nurse training in trauma/combat casualty care, streamlining the patient admissions and tracking procedures, training over 600 Red Cross volunteers, and expanding intensive care capabilities. Despite all the preparations, the MTF provided continuous care to its beneficiaries. They were able to do so by using reserves to augment their staff.

Throughout the DESERT SHIELD preparations, Captain Reed kept abreast of the MTF's progress through reports from his directors and through direct observation. He also provided direction and offered guidance when needed. His organizational skills and knowledge of the MTF's capabilities ensured that his subordinates were working as a team. Captain Reed provided order and created a sense of urgency throughout the MTF. Even though staff members were working overtime, morale was high since they were accomplishing their mission despite its difficulty.

By the time DESERT STORM commenced in January 1991, the MTF was fully ready to accept large numbers of combat casualties. Fortunately, war casualties were small. The MTF treated only five patients from DESERT STORM as they were sent home.

Despite the small number of casualties, the preparations for war proved valuable for the MTF. The MTF accomplished a difficult mission by working as a team which further increased morale. Additionally, the staff learned how to prepare for war in event another major contingency developed, and established coordination and standardized protocols with MTFs of other services. Finally, Captain Reed firmly established his presence in the MTF and earned the respect of his staff.

Case Questions:

   1. Did Captain Reed take the right approach in leading the MTF when preparing the MTF during DESERT SHIELD? What other approaches could he have taken?

   2. How did DESERT SHIELD and DESERT STORM play to Captain Reed's strengths?

E. CASE THREE: CREATING THE VISION

After the DESERT STORM ground campaign ended in March 1991, the MTF breathed a sigh of relief that the operation ended with few casualties. The uncertainty and urgency created by DESERT STORM was over. The MTF performed well, had

reason to be proud, and could continue with projects set aside during wartime preparations.

Captain Reed was also anxious to continue with the improvements he began prior to DESERT STORM. Particularly, he wanted to focus on improving quality. To do so, he intended to introduce Total Quality Leadership (TQL) into the MTF.

Captain Reed received instruction in TQL techniques at the Senior NAVLEAD Course and agreed with its basic philosophy. Additionally, the Department of the Navy and BUMED embraced the Total Quality Leadership (TQL) philosophy and encouraged subordinate commands to implement TQL. Finally, the TQL framework meshed with Captain Reed's systems view of the organization that he developed through his background in Epidemiology.

Total Quality Leadership

Captain Reed introduced TQL into the MTF initially by creating an Executive Steering Committee (ESC). The ESC consisted of the CO, XO, all directors, and the Command Master Chief (CMC). Additionally, Captain Reed sent a memorandum to all MTF personnel which outlined the basic philosophy of TQL and emphasized his commitment to TQL. Moreover, in the memorandum, he challenged everyone to embrace TQL and strive for continuous quality improvement. A copy of Captain Reed's memorandum is included as Appendix H.

Once the ESC was established, Captain Reed wanted to develop a vision statement, mission statement, guiding

principles, and a set of strategic goals for the MTF. Through their development, he believed teamwork and unity of purpose within the MTF would increase. However, he also realized that the process used to develop the mission, vision, goals, and guiding principles would greatly influence their acceptance by the MTF.

Case Questions:

1. How should Captain Reed go about creating the vision, mission, goals, and guiding principles for the MTF? Who should be involved with the decision making process? Why?

2. What are the advantages of introducing TQL concepts into the MTF? How does the TQL philosophy relate to Captain Reed's goal of raising organizational standards and values?

3. What kind of resistance to TQL would you expect at an MTF? Where would the sources of resistance be located?

Creating the Vision.

Instead of developing the command's vision on his own, Captain Reed believed that the ESC should develop the vision as a team. He believed that such an approach was consistent with the TQL philosophy; would foster teamwork and cooperation between the CO, XO, CMC, and directors; and would likely result in greater acceptance by the MTF. With the decision made, the ESC went to work.

The ESC met once a week for nearly six months to develop the MTF's vision statement. During that period, they also developed the MTF's mission statement, strategic goals, and

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guiding principles. Captain Reed facilitated the meetings and
offered input when he felt necessary. However, the meetings
were largely democratic in nature. All ESC members had
opportunity to provide input and offer suggestions.

The process used by the ESC in developing the vision,
mission, goals, and guiding principles proved valuable for the
ESC members since they were forced to decide what the MTF was
all about and what it needed to do to improve. The ESC
decided that the MTF could not be everything to everyone.
However, when it came to health care, they wanted the MTF to
be their beneficiaries' first choice. Therefore, the ESC
decided that the vision statement should be, "We want to be
your first choice!"

To be the first choice for health care, the MTF would have
to guard against bureaucracy, enhance teamwork, identify key
processes for improvement, and ensure that valid data
justified actions taken. The guiding principles developed by
the ESC incorporate the above requirements. Similarly, the
six strategic goals developed supported the vision statement
by emphasizing such things as the need for customer service
orientation, commitment to professionalism and readiness, and
interdepartmental cooperation. The vision, mission, guiding
principles, and strategic goals developed by the ESC are
included in Appendix I.

Captain Reed was satisfied with the ESC's work. However,
he realized that the vision statement, mission, guiding

principles, and strategic goals were useless unless they were clearly communicated throughout the MTF. Additionally, he realized the broad concepts embodied in the vision statement and strategic goals were nothing more than words unless they could be translated into specific actions.

Case Questions:

1. How effective do you think that Captain Reed's approach was when developing the command's vision statement, mission statement, guiding principles, and strategic goals? What are the advantages of using a team-based approach? What are the disadvantages?

2. Do you think the vision statement, mission statement, guiding principles, and strategic goals developed by the ESC are appropriate for the MTF? Why or why not?

3. How should Captain Reed communicate the command's vision, guiding principles, and strategic goals to the MTF? What media should he use?

4. How should he go about translating the broad strategic goals into specific actions?

Communication the Vision and Planning for Action.

Captain Reed held a Captain's call, used the chain of command, and sent E-mail messages to communicate to the MTF the command's vision, mission, guiding principles, and strategic goals. In addition, posters printed and posted on bulletin boards throughout the MTF and orientation briefs directed at new MTF staff members were utilized to communicate the vision and strategic goals. Finally, the MTF's mission and vision statements were routinely printed in command newsletters and ceremony programs.

MTF staff members quickly learned the vision statement and strategic goals after the multi-media communication blitz. Transmitting the message to the MTF had been a relatively easy task. However, Getting the MTF to accept the vision statement and take steps towards reaching the strategic goals would require more work.

Captain Reed decided to solicit the help of the MTF's department heads to translate the MTF's broad strategic goals into specific plans of action. The department heads were instructed to get together and develop specific strategies and tactics to reach each of the six strategic goals. Moreover, when deciding on specific tactics, action officers, start dates, and completion dates were to be assigned.

The department heads worked on the specific strategies and tactics for nearly a year before completion. During the year of deliberations, the department heads were forced to evaluate the operations of their departments to find areas for improvement. Once areas for improvement were identified, specific strategies for improvement were planned. A list of the strategies and tactics developed is included as Appendix J.

Throughout the strategy and tactic development process, the department heads were forced to work with one another to agree on specific actions to recommend to the ESC. Since all department heads were involved, physicians, nurses, and administrators were represented. As with the ESC's

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development of the vision statement, the department heads'
deliberations were democratic; each had opportunity to offer
input. Moreover, the department heads developed their
recommendations free from ESC influence. ESC guidance was
offered only when requested by the department heads.

Case Questions:

1. **What are the advantages and disadvantages of the
    approach Captain Reed used to develop specific strategies
    and tactics for each strategic goal? Do you feel as though
    the process was too time consuming? What other approaches
    could he have taken?**

2. **Now that specific strategies and tactics are developed
    for each strategic goal, what steps can Captain Reed take
    to implement the plans?**

3. **Could this process be used during times of crisis. For
    example, could have Captain Hendrix used these techniques
    when he took over the MTF?**

QMBs and PATs

The ESC quickly approved the specific strategies and
tactics the department heads submitted. The department heads
were then tasked to implement the strategies and tactics
within their departments where appropriate. Additionally,
each month department heads held quality improvement meetings
to assess the progress made in each quality improvement area.
Finally, at each Friday director meeting, Captain Reed
expected reports on quality improvement from all directors.
The monthly quality improvement meetings and weekly quality
reports to the CO served to maintain focus on quality issues.

In addition to the involvements with the directors and department heads, Captain Reed established a command TQL coordinator to help promote TQL throughout the MTF. To promote TQL, the coordinator developed education programs for orientation, advised the ESC and department heads in TQL areas, and served as a liaison between the ESC and the various Quality Management Boards (QMBs) and Process Action Teams (PATs) that were eventually developed. The TQL coordinator received formal TQL training through the Navy's TQL basic, TQL facilitator's, and TQL tools courses.

Quality Management Boards in the TQL framework are chartered by the ESC in order improve quality in a specific process. Members of QMBs normally consist of middle managers who own the process. In Charleston Naval Hospital, the ESC formed two QMBs, one for health promotion and one for TQL education and department head training. A MTF director served as a facilitator for each of the QMBs, but was not the QMB team leader.

Process Action Teams in the TQL framework are set up to accomplish specific tasks in a specific time frame. PAT's are normally transitional in nature and consist of individuals who actually work in the process desiring improvement. At Charleston Naval Hospital, six PAT's were created in areas ranging from medical records to food service. All PATs designated by the ESC contained members from more than one MTF department. The PATs also provided a forum for those closest

to the problem, those actually working in the process, to offer suggestions for improvement.

By just designating a PAT to investigate a specific process, the ESC drew command attention to areas that they believed important. Moreover, their interdepartmental membership allowed the PATs to approach problems with greater perspective. Harmful parochialism and departmental interests were limited. Decisions could be made in the best interest of the MTF rather than the best interest of a particular department.

The six PATs at Charleston Naval Hospital proved effective in providing suggestions to improve the processes they were tasked to investigate. Examples in which PATs helped improve quality included food service and inpatient medication. The food service PAT improved customer service to patients by suggesting ways to ensure food delivered to patient rooms was hot. Similarly, problems with inpatient medication doses were improved due to suggestions from the Inpatient Medication PAT.

As with the department heads, the QMBs and PATs met regularly to discuss their progress in quality improvement. Additionally, the QMBs and PATs kept the TQL coordinator informed of their progress. The TQL coordinator then reported the results to the ESC during their weekly meetings. Once areas were identified for improvement, the chain of command took action to make the improvements.

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Case Questions:

1. Do you feel that the QMBs and PATs contribute to the chain of command's effectiveness or acts as a detriment? Why?

2. Do you feel that the reporting requirements of the directors, department heads, QMBs, and PATs are adequate to maintain the focus on quality improvement? What other things could be done to increase the awareness for quality improvement within the MTF?

TQL: The Good and Bad

Besides improvements brought about by suggestions from the PATs, the introduction of TQL into the MTF gave MTF leaders new tools to solve problems. The vision statement, mission statement, guiding principals, and strategic goals gave MTF leaders a framework in which to assess problems. Prior to the introduction of TQL, new orders or regulations were frequently written to solve minor problems. With TQL, problems were solved by looking at the process, collecting data, performing tests, checking results of the tests, and implementing a plan for improvement.

The TQL problem solving process often resulted in long term corrections to problems vice temporary, "quick fix" solutions. Additionally, before TQL, people were often the focus of problems. After TQL, focus shifted to correcting and improving processes.

TQL increased the MTF's awareness of quality improvement and customer service. Even if all personnel did not embrace, or understand, TQL techniques, they were all aware of the

MTF's mission, vision statement, and guiding principles. They were also aware that the CO, XO, and directors valued quality improvement and customer service at all levels of the organization. Prior to TQL, the perception was that quality improvement was the responsibility of the QA office. Now, quality the responsibility for all.

Despite the benefits of TQL, the implementation of TQL MTF did not come without costs. The meetings of the ESC, QMBs, and PATs required large time commitments from senior MTF leaders. Part of the time expended could be attributed to learning and the newness to the programs. Aside from time spent learning the system, the team-based, democratic approach to solving problems required more effort and time than a top-down and directive approach.

The implementation of TQL also went against prevailing Navy attitudes towards the role of command and the use of the chain of command. Old paradigms had to be broken and new skills learned. Instead of simply issuing orders from the top, team building, communication, meeting facilitation, and conflict management skills were required. Acceptance of the process and the learning of new skills took time. For those set in their ways, the changes were not easy.

Additionally, integrating TQL below the department head level proved difficult. Due to the high turnover of military personnel in the MTF, it was difficult to maintain a core of TQL trained personnel. Consequently, the only TQL training

received by many consisted of a two-hour brief during orientation. Without adequate TQL training, the majority of MTF staff members were not able to implement TQL problem solving techniques.

Case Questions:

1. Implementing TQL into the MTF required the commitment of time and energy from everyone in the organization. Do you feel as though the benefits of implementing TQL outweighed the costs at Charleston Naval Hospital? Why?

2. How should MTF leaders address the TQL implementation difficulties? What can they do to implement TQL lower in the organization? How can they make change for the organization easier to accept?

F. CASE FOUR: MANAGING TODAY AND THE FUTURE

Despite the time involved and the difficulties with pushing TQL down to lower levels of the organization, Captain Reed was generally pleased with the implementation of TQL in the MTF. He was now ready to implement other programs and ideas which he hoped would improve the MTF. Those ideas included expanding department head training, empowering subordinates, improving the awards system, and improving communications.

Department Head Training

With the exception of the residency program, training programs within the MTF were limited primarily to clinical areas, personal qualification system training, and general military education training. These programs were augmented by

sending individuals to formal military schools when quotas and funding were available. Below the department head level, personnel generally received adequate clinical and professional training necessary to do their jobs. However, the department heads were often put into management positions without adequate management training. Moreover, few had the opportunity to attend formal schools to receive needed training due to the limited number of billets available.

To correct the training deficiency, Captain Reed decided to emphasize professional education at the department head level. He believed that the department heads formed a critical link between clinicians and the directors. By focusing professional education on department heads, they could pass lessons learned to lower levels of the organization through their subordinates. Similarly, by having not only department heads but also directors attend the training, directors could get a better understanding of issues important to department heads.

Prior to Captain Reed's arrival, department head training was conducted infrequently and was often poorly planned. Captain Reed desired to formalize the department head training by holding it every six months over a three to five day period. Both department heads and MTF directors would attend the training. To show support and to offer command insight to the training, the CO and XO would also attend.

After the MTF training officer finalized details of the training program and Captain Reed approved it, the first training session was conducted in the Fall of 1991. To minimize distractions, training was held in a Charleston hotel. All department heads and directors in attendance were encouraged to turn off their beepers and allow their subordinates to run his or her department or directorate for the week. Essentially, those in attendance were TAD without orders.

Topics covered in the training included management and leadership issues such as TQL, fiscal management, discharge planning, and manpower development. Personnel within the hospital, as well as those from the local community, served as primary instructors. Although many of those providing instruction had little experience teaching, they were familiar with the subject area.

Material was presented through lecture and case discussion. Additionally, role playing was frequently used to stimulate thought and discussion about areas such as customer service and interdepartmental relations.

Besides providing instruction in management and leadership, the training program gave MTF leaders opportunity to get together outside the MTF environment. The forum allowed MTF directors and department heads to learn more about each other through interaction and discussion. Through the interaction, the department heads developed professional

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relationships and gained a better understanding of operations in other MTF departments. Better understanding and teamwork developed through the training improved camaraderie and helped unify the MTF. Finally, the MTF personnel who assumed the director and department heads' positions during the week had an opportunity to develop their leadership abilities.

The first department head training session was well received by the directors and department heads that participated. Each left with a better understanding of the MTF and a better understanding of the management issues covered in the training. After a week away from the MTF, most were ready to get back to work and implement what they had learned. They were also eager to pass on what they learned to their subordinates. Finally, they looked forward to the next scheduled training session.

Case Questions:

1. Do you feel that Captain Reed's emphasis on professional education at the department head level was appropriate? Should the training have focused at the director level? Why?

2. Do you think that the department head training would have been as successful if held at the MTF? Where else could the training have been conducted?

3. What are the best teaching methods for training? Do you think that role playing is a good idea?

4. What are the advantages and disadvantages of using personnel within the MTF to conduct the training? How about using personnel from outside the MTF to conduct the training?

5. Is it a good idea to include both the department heads and directors in the same program? What are the

advantages/disadvantages of having the CO and XO attend the
training?

Empowering Subordinates

Captain Reed believed that to improve quality within the
MTF, personnel within the MTF must be empowered to do their
jobs well. In order to empower his subordinates, he realized
that he must set a positive example. Additionally, he
realized that he must trust his subordinates, support their
decisions, and listen to their ideas. Finally, he realized
that he must recognize those that perform well and provide
assistance rather than mere criticism.

Many of the practices he implemented during his command
were intended to empower subordinates. By not attending daily
director meetings, Captain Reed forced directors to work out
solutions to problems among themselves. Once directors made
decisions, he supported them. Moreover, he realized that the
directors were human and were capable of making mistakes.
When mistakes were made, Captain Reed emphasized the lessons
learned from the mistakes rather than blaming individuals.

Whenever the situation permitted, Captain Reed encouraged
his subordinates to get involved with making key MTF
decisions. The selection of the MTF's vision statement,
mission statement, guiding principles, and strategic goals
epitomized the use of subordinates in decision making
processes. Similarly, Captain Reed used teams and group input

when deciding to implement a Director for Strategic Planning position in order to improve CAMS/MTF coordination.

Although he allowed subordinates to make many decisions, Captain Reed still provided guidance and exerted influence on decisions they made. He provided guidance by clearly stating his values and the values he expected his subordinates to follow. Through the use of memos, Captain's calls, and E-mail messages, he communicated those values as he did with his fitness report memo. Captain Reed's support of the command's vision statement, guiding principles, and strategic goals further encouraged subordinates to make decisions with the command's interest in mind.

Personal Awards

In addition to allowing subordinates to make decisions, Captain Reed believed that recognizing outstanding performance was necessary to empower individuals. One way to provide recognition was through the military awards system. However, Captain Reed realized that the awards system in place at the MTF was inadequate. Awards were written inconsistently. Furthermore, many awards were presented late, if presented at all. Ironically, the awards program demotivated MTF personnel because of inconsistencies and delays.

Awards recommendations were approved by an awards board consisting of the XO, several directors, and personnel from administrative departments. The board did not contain representatives from every directorate nor did it have

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consistent standards for awards submissions. Without representation, the board often could not make award decisions because of inadequate knowledge of the individual or circumstance that warranted recognition. Without consistent standards, awards were often submitted incomplete or submitted for inappropriate reasons. Consequently, award recommendations were often sent back to the departments for rework and resubmission which created delays.

Once the awards board approved all awards, they were typed in the correct format by a single administrative clerk. With only one clerk typing the awards, administrative delays were the norm. In many cases, personnel receiving awards had transferred or exited the service before the awards were readied.

Since the awards system was not achieving its primary purpose, recognizing deserving individuals in a timely fashion, Captain Reed instructed his directors to come up with a plan to correct the problem. After deliberations, the directors decided they would all participate on an awards board that met weekly. Additionally, the department heads would be responsible for submitting the awards in the correct format with a copy on a floppy disk to facilitate corrections and printing. The new system improved the award turnaround time, involved the chain of command in the decision making process, and improved the quality and consistency of awards presented.

The awards presentation also became more visible with the introduction of weekly awards ceremonies, usually held at 1500 on Wednesdays. Awards were also presented during MTF special events and inspections. After the awards were presented, lists of those receiving recognition were listed in the command's monthly newsletter.

The emphasis Captain Reed placed on correcting the military awards program impacted other awards programs in the MTF. As a result, new emphasis was placed on sailor and civilian of the month programs and length of service awards. Additionally, the increased awareness for recognition prompted many MTF leaders to more frequently give verbal praise and positive feedback to outstanding personnel.

Recognizing exemplary performers helped improve morale within the MTF and gave many MTF staff members a reason to strive for improvement. Even though staff members knew that every individual could not receive an award, they knew that the command cared enough to notice a job well done.

Case Questions:

1. What are the benefits of empowering subordinates to perform well as opposed to forcing performance through authoritarian means? What are the limitations?

2. What other things could Captain Reed do to empower the MTF staff?

3. Do you feel that Captain Reed's emphasis on the military awards system was appropriate? In what other ways could outstanding individuals be recognized?

4. **What role do awards and recognition play in improving quality in an MTF? How do awards and ceremonies affect the culture of the MTF?**

Open Communications

Besides providing recognition and allowing others to make decisions, Captain Reed believed he needed to understand the concerns of the MTF staff in order to empower them. To do so, Captain Reed maintained open lines of communication to his office. At all times, he ensured that he was approachable to his XO and directors by treating them as colleagues as opposed to subordinates. He welcomed their opinions and listened to their grievances at any time. Furthermore, he treated everyone with respect, regardless of their views.

TQL Suggestion Box

In addition to the usual chain of command, Captain Reed encouraged MTF staff members at all levels to offer suggestions for improvement through a suggestion box maintained by the TQL coordinator. Each week the suggestions were compiled by the TQL coordinator and presented at the MTF's ESC meeting. The ESC reviewed each suggestion and took action when appropriate. Personnel who provided input for change were made aware of actions taken through their chain of command.

E-Mail

The MTF's E-mail network was another medium which Captain Reed used to communicate with the MTF. With E-mail, every

office in the MTF could communicate with another instantly. Furthermore, anyone with access to a computer could send the CO a message directly. Similarly, the Captain Reed could send any office in the MTF a message directly.

Through the use of E-mail, anyone in the MTF could quickly get the CO's or XO's attention. Although the system facilitated rapid communications, if the system was not used with discretion, the chain of command could be left out of the information loop. No policy or controls were in place on E-mail to encourage correct use.

Additionally, since the network was open to anyone with access to a computer, the effectiveness of E-mail as a communication medium was often degraded because of message traffic volume. The high volume of E-mail traffic required MTF staff members to spend additional time sorting through messages to determine what was important. Non-job related messages were often mixed with job related ones. The time delays discouraged many from using the system.

Without E-mail policy and controls, those who did use the system often used it inappropriately. Messages would often be sent to the wrong address or E-mail would be used when another medium would have been preferable. For instance, E-mail was often used to deliver bad news to another staff member when a phone call or personal visit would have been more appropriate.

Despite E-mail difficulties, Captain Reed believed that E-mail enhanced his ability to maintain communications with the

MTF. The system was quick, allowed for rapid feedback, and was universally accepted throughout the MTF. Improved communications allowed the MTF to better operate as a coordinated team. Problems and suggestions could rapidly be raised, discussed, and resolved resulting in improved service and higher morale.

Case Questions:

1. What are the benefits and limitations of using means other than the chain of command to obtain information about the MTF such as the TQL suggestion box and E-mail? Do such means strengthen or weaken the chain of command?

2. Virtually all commands uses suggestion boxes in one form or another. How can the MTF ensure that it is used well?

3. Should controls be placed on the use of the MTF's E-mail network? If so, what controls should be implemented?

4. What kind of E-mail policies should be in place? Who should institute these policies?

External Communications

Since the mission of the MTF was to provide quality health care to the fleet and the surrounding community, Captain Reed was concerned about communications external to the MTF. Communications between the MTF, the naval base, and BUMED were necessary to ensure that needs were met and health care support was provided. Similarly, beneficiaries required information about the MTF's capabilities in order to make informed health care decisions. Communication was also

important to maintain the positive community relations that Charleston Naval Hospital historically enjoyed.

For the most part, communications within the military chain of command were routine. Needs of the MTF and support requirements of the Charleston Naval Base and BUMED were voiced through phone conversations, messages, memorandums, and reports. Captain Reed also communicated with the naval base by attending weekly COMNAVBASE CO staff meetings and by participating on the COMNAVBASE TQL Executive Steering Committee.

While communications with the chain of command were normally routine, communications with the Charleston community were not. To provide services, the MTF maintained relations with beneficiaries, network health care providers, and community leaders. Each groups' needs were met through separate communications media.

Most of the communication needs between beneficiaries and health care providers were provided by MTF staff members. For example, the CAM office routinely published informational brochures describing the CAM program to its beneficiaries and network providers. Similarly, the MTF routinely held health fairs to increase health awareness throughout the community and fleet. Special one-day prostrate screening clinics, blood drives, and community volunteer programs also were used to increase health awareness. The communication efforts by MTF

staff members provided information and served as positive public relations for the MTF.

Captain Reed used his position to promote the MTF through his involvement with local organizations and through speeches to community groups. As CO he attended all South Carolina Hospital Association CEO meetings, and was a member of the Charleston Chamber of Commerce. He was also an active participant on the Chamber of Commerce Military Affairs Council. Finally, Captain Reed often spoke to retired officers groups, veterans associations, and federal employee organizations in order to promote the MTF, to provide information, and to foster positive relations.

Close ties with the community also helped ensure the success of the CAM demonstration. The close ties facilitated the creation of the CAM provider network. After the network was established and operational, open communications enabled provider and beneficiary concerns to be addressed and resolved quickly.

Case Questions:

1. How does Captain Reed's involvement with the community and his concern with communications external to the MTF reinforce the vision and guiding principles established by the MTF? Is it consistent with the MTF's role as a provider to the community?

2. In what ways would external communications and community relations affect quality and customer service within the MTF?

On the Chopping Block

The support of the Charleston community towards the MTF was readily apparent in March 1993 when the Secretary of Defense recommended to Congress that Charleston Naval Hospital and the Charleston Naval Base be closed as part of military downsizing. The announcement came as a surprise to many in the community and the MTF, even though the MTF and naval base were barely spared in previous cuts. Without the military, community leaders feared economic ruin for Charleston. Moreover, many in the community, especially retired military, feared the loss of health care benefits without the hospital.

Personnel within the MTF were also disappointed with the closure announcement. Since 1988, the MTF leaders and staff worked hard to improve the MTF and establish the CAM network. Through hard work, the MTF performed admirably through Hurricane Hugo and DESERT STORM. Additionally, they corrected JCAHO discrepancies, implemented TQL, improved training programs, and improved communications. Many felt all the hard work would go to waste with MTF closure. Most felt it was futile to put forth additional efforts so as to make further improvements.

The Secretary of Defense's recommendation for closure created uncertainty for the MTF staff and the community. To begin with, many found the whole base closure process confusing. Also, final word on whether the MTF would close would not be given until July after Congressional review. In

the meantime, civilian workers wondered if they would lose
their jobs, military members were concerned about the
possibility of transfer, and beneficiaries wondered if they
would lose access to health care. Because of the possibility
of closure, morale in the MTF began to decline.

Case Questions:

1. **What should Captain Reed do to help the MTF cope with
the declining morale?**

2. **Should the MTF begin making plans for closure
immediately, or should it wait until after the
Congressional review period in July?**

Coping with Uncertainty

Captain Reed believed the best way for the MTF to deal
with the uncertainty was to keep everyone informed of the
current situation. Many did not understand the base closure
process nor did they know what would happen to them if the MTF
were to close. To provide information about the situation,
Captain Reed held several Captain Calls which described the
base closure process. Additionally, he directed that classes
be held describing civilian and military benefits, retirement
benefits, job relocation programs, and housing assistance.

In addition to providing information, Captain Reed
directed the ESC to take preliminary steps to prepare for
possible closure. However, nothing substantial would be done
until a final decision was made by Congress in July. There
was no point in spending too much effort on closure

preparations until Congress made its decision. Day-to-day care of patients took priority.

By late May 1993, the ESC decided to form nine QMB's to investigate areas which base closure would effect. The model used to form the QMB's was derived from another Navy MTF, which was previously slated to close. The nine QMBs formed were patient care, dental, military personnel, civilian personnel, occupational health, equipment, facilities, and administrative issues. Each QMB consisted of personnel who were responsible for running the process under investigation. The QMBs were formed as a precautionary measure. Substantial work would not begin until base closure was certain.

Change of Command

On 4 June 1993, Captain Simon was to assume command of the Charleston Naval Hospital. In addition to the uncertainty caused by the base closing recommendation, MTF personnel were unsure of changes occurring in the Post Cold War military. Concerns over force reductions, early retirements, and the possible introduction of gays in the military preoccupied the thoughts of many.

Despite the uncertainties, the MTF staff was still dedicated to providing quality care to its beneficiaries. The directors and department heads embraced the changes made under Captain Reed and were proud of the progress made over the years. Although Captain Reed would be missed, the MTF was ready to face the future.

Case Questions:

1. Did Captain Reed take appropriate action to address the uncertainties created by the base closure recommendation? What other actions could he have taken?

2. How should the turnover between Captain Reed and Captain Simon be conducted? What issues should be addressed?

3. How does the situation faced by Captain Simon differ from the situation faced by Captain Reed when he assumed command? How about the situation faced by Captain Hendrix?

4. If you were Captain Simon, what actions would you take upon assuming command of the MTF?

IV.   CASE ANALYSIS

A.   INTRODUCTION

This chapter provides a brief analysis/commentary of the major management issues contained in the four case study sections.   The analysis for each case study section is broken down into three parts: part one provides a summary of the case study section, part two includes a list of major management themes, and part three contains a brief commentary about the major management themes contained in the section.

B.   CASE ONE: "A NEW CO ARRIVES"

1.   Case Summary

Case One covers the entire period of Captain Hendrix's command at the Charleston Naval Hospital.   The case first describes Captain Hendrix and initial MTF problems, followed by steps he took to correct the initial problems.   Next, JCAHO problems are introduced with descriptions of their resolution. The case ends with a detailed description of the MTF's reaction to Hurricane Hugo.

2.   Major Management Issues

Case one contains four major management issues: decision making/problem solving, interpersonal relations, leadership styles, and crisis management. Although each issue is developed in separate portions of the case, the issues are

interrelated. For instance, Captain Hendrix's leadership and interpersonal relations styles influence how he makes decisions and solves problems.

The first issue, decision making/problem solving, is emphasized when Captain Hendrix first assumes command of the MTF and again after the JCAHO survey in 1989. The second and third issues, interpersonal relations and leadership styles are emphasized by Captain Hendrix's relationship with his directors, the MTF staff, and with Captain Young. Finally, the forth issue presented in case one, crisis management, is emphasized by Captain Hendrix's actions during Hurricane Hugo.

3. Analysis

The impact of Captain Hendrix's charismatic personality and leadership style is evident throughout the case. Given the situation at the start of his command, Captain Hendrix's charisma, and top-down leadership approach was effective. He was particularly effective in restoring confidence in the MTF's leadership, in ending the equal opportunity/discrimination problem, and in getting the directors to better cooperate with one another.

Captain Hendrix's style of getting to the bottom of problems and taking forceful action was directly opposite of his predecessor. Consequently, small issues no longer grew into large problems. Similarly, the problems that existed at the start of his command were quickly corrected. As Captain

Hendrix corrected problems, confidence in the MTF's leadership was restored. Such a quick turn around in the MTF would probably not have been possible if he assumed a hands-off leadership approach.

Captain Hendrix's charisma also enabled him to freely exert his influence on his directors without creating animosity. To the directors, Captain Hendrix was in clearly in charge. They respected his authority and admired him as a person. Captain Hendrix was a people-person. They expected him to contact department heads directly or walk around the MTF to gather information. Without charisma and earned respect, a top down leadership approach would likely result in animosity and resentment among the directorates. With resentment, the directors would not be likely to support decisions made nor would they be willing to offer advice and suggestions freely.

As Captain Hendrix demonstrated, charisma and a top down leadership approach has benefits. Such a leadership approach allows rapid improvement and change to occur within an organization. The quick end to the equal opportunity problem could be directly attributed to Captain Hendrix's top down leadership style. Essentially, Captain Hendrix became the focal point of the MTF providing necessary direction and unity of purpose for the organization.

Direction and unity of purpose within the MTF was critical during the Hurricane Hugo crisis. Under Captain

Hendrix's leadership, the MTF successfully prepared for a worst case storm scenario. As it turned out, the preparations allowed the MTF to perform their mission when many other providers could not. By pulling together and succeeding despite the adverse working environment, pride and morale within the MTF skyrocketed. If the MTF had failed in its mission after Hugo, morale and pride may have been adversely effected.

Hurricane Hugo was also the first major external event described in the cases that provided opportunities for the COs to demonstrate their abilities. Hurricane Hugo provided an opportunity for Captain Hendrix to take charge and rally the MTF into action. Since he was such a dominant force within the MTF, the success of the MTF was also a success for him.

C. CASE TWO: "SLOWLY BEFORE THE STORM"

1. Case Summary

Case two covers the first eight months of Captain Reed's tenure as MTF CO. In case two, Captain Reed first establishes himself as CO, then takes steps to improve coordination between the CAMS office and the MTF. A description of the formation of the Directorate for Strategic Planing (DSP) follows. Case two ends with a description of the MTF during DESERT SHIELD and DESERT STORM. In the DESERT STORM segment, Captain Reed's role during the crisis is emphasized.

2. Major Management Issues

Case two's major management issues include transition management, the establishment of standards and organizational values, the transition to a decentralized management style, and leadership during crises. Additionally, case two highlights the differing leadership styles of Captains Hendrix and Reed.

3. Analysis

As new CO, Captain Reed is faced with the decision of how to establish himself after an immensely popular and successful predecessor. After Captain Hendrix's two years as CO, the MTF was in relatively good shape. The MTF had accomplished much and morale was high. Nevertheless, Captain Reed still wanted to make improvements.

By acting slowly and initially making small, symbolic changes, Captain Reed was able to make an impression on the MTF without significantly diluting successes attributed to Captain Hendrix. Moreover, Captain Reed's emphasis on raising standards and establishing organizational values served as a prelude to his agenda of advancing quality improvement, decentralizing decision making, and introducing TQL into the MTF.

Captain Reed further advanced his agenda of decentralizing decision making and empowering subordinates through the creation of the Directorate for Strategic

Planning. To the XO and the directors, the process used to decide on the DSP's implementation differed from past decision making processes. Unlike the past, they had successfully worked together and came to an agreement with minimal influence from the CO. The decision making process was not as quick as that under Captain Hendrix. However, the situation was also different. The MTF was running fairly smoothly at the time; an immediate solution to the CAM/MTF coordination problem was not critical. Instead, a workable, long-term solution was needed.

Like Captain Hendrix, Captain Reed's presence commanded immediate respect. He was tall, appeared confident, and was enthusiastic. He looked and acted like a leader. Additionally, his reputation as an outstanding epidemiologist and leader preceded him to the hospital. He possessed a doctorate degree in public health care. Although not a physician, his credentials and reputation were impeccable. To many physicians in the MTF, credentials and reputation were critical.

Captain Reed firmly establish his position as MTF CO once Operation DESERT SHIELD commenced. The crisis provided a unique opportunity for Captain Reed to demonstrate his exemplary organizational and supervisory skills. From the onset of DESERT SHIELD, Captain Reed effectively coordinated the MTF in preparing for wartime casualties. His ability to conduct a quick study, and come up with feasible solutions to

problems impressed the MTF's directors and others in the chain of command.

Captain Reed also benefited from the DESERT SHIELD crisis because it gave him opportunity to transfer his adversarial XO. Without the XO, Captain Reed was able to exert his influence and provide direction to the MTF more directly. Although Captain Reed favored decentralized decision making, the urgency of the situation required top-level direction and intervention to ensure MTF efforts were coordinated. With greater influence on the MTF, successes of the MTF during DESERT SHIELD and DESERT STORM were more closely tied to Captain Reed's leadership. As a result, he was able to earn the respect of the MTF staff.

D. CASE THREE: "CREATING THE VISION"

1. Case Summary

Case three deals primarily with the implementation of TQL in the MTF. Included is the development and communication of the MTF's vision statement, mission statement, strategic goals, and guiding principles. Descriptions of MTF QMBs and PATs follow. Case three ends with a description of the good and bad effects of TQL in the organization.

2. Major Management Issues

Case three's major management issue is the implementation of TQL into an organization. Included with TQL implementation is the process of creating and communicating

the organization's vision statement, mission statement, strategic goals, and guiding principles; the use of teams to solve problems; and difficulties associated with implementing change.

3. Analysis

Case three begins immediately after DESERT STORM. At that time, Captain Reed had established himself as CO, and the MTF was anxious to continue with programs postponed due to war preparations. Since the MTF was receptive and motivated, he used the opportunity to introduce TQL into the organization.

For TQL to be successful, it must have the support from senior leaders. Captain Reed ensured top level support through his memorandum to all MTF staff and through his involvement with the ESC. His commitment to TQL encouraged the directors to embrace the philosophy. Additionally, the directors were accustomed to Captain Reed's decentralized leadership style. To them, the MTF was already employing many TQL techniques.

The creation of the MTF's vision statement, mission statement, guiding principles, and strategic goals epitomized the use of teams to solve problems. The process was democratic and a consensus between all ESC members was reached. Since they participated in the deliberations, each team member supported the results. Moreover, the process of developing the MTF's vision statement and strategic goals

forced ESC members to develop a long-term view of the organization.

The team-based decision making process the ESC used to develop the MTF's vision and strategic goals took six months to complete. Similarly, the team-based approach the MTF's department heads used to develop strategies and tactics to reach the MTF's goals took an additional year. Despite the time required, team-based decision making was appropriate in the development of the vision and strategic goals since it was imperative that directors and department heads accept and support them.

The creation and communication of the MTF's vision, guiding principles, and strategic goals benefited the MTF. The vision statement and guiding principles formed a framework for which MTF staff members could make decisions and act. With a common vision and guiding principles, the MTF was more likely work together towards a common goal. As a result, quality and customer service would likely improve.

Team-based decision making processes were also effectively used with the PATs. The PATs were able to avoid departmental parochialism which may have resulted in poorly made decisions. Additionally, the use of TQL tools to gather data tended to shift the blame of problems from people to processes. Such a shift in focus helped improve interdepartmental relations within the MTF.

One of the TQL implementation problems the MTF faced was spreading the philosophy below the department head level. Spreading TQL was difficult because of institutional biases and lack of education. The TQL philosophy countered the prevailing Navy view of authority and the use of the chain of command. To change deep seated views, time and education were required. However, the constant turnover of MTF staff made training difficult.

Efforts to provide TQL education through orientation briefs increased awareness of TQL. However, with only a few hours available, a complete understanding of TQL could not be developed. In some cases, continued TQL education occurred through on-the-job training. In many other cases, no addition TQL education occurred. As a result, TQL below the department head level spread slowly and inconsistently.

E. CASE FOUR: "MANAGING TODAY AND THE FUTURE"

1. Case Summary

Case four describes MTF efforts to continue quality improvement within the organization. Case four begins with a description of the MTF's implementation of department head training. A description of Captain Reed's efforts to empower subordinates follows. In the empowerment section, details of decentralized decision making, recognition of individuals, and communications within the MTF are included. Case four concludes with the announcement of possible base closure and

describes the status of the MTF at the end of Captain Reed's tenure as CO.

2. Major Management Issues

The management issues contained in the final case section include professional education, empowerment of subordinates, and communications internal and external to the organization. The issues are presented as methods to improve quality within the MTF. At the end of the case, the issue of management during periods of uncertainty is highlighted.

3. Analysis

Captain Reed emphasized the development of subordinates, empowerment, recognition of outstanding individuals, and communications. By doing so, he hoped to improve quality and professionalism within the MTF.

The department head training program Captain Reed started had three primary benefits. First, through the program, Captain Reed clearly showed he was committed to contributing to the professional development of his staff. By taking care of his staff, his staff would hopefully reciprocate by performing well for him. Secondly, the information learned through the training enabled the department heads do a better job managing their departments. Better managed departments would result in a better MTF. Finally, the department head training served as a forum for senior MTF leaders to get away from the daily hassles of the

MTF and, as a group, to discuss issues of mutual concern. The setting enabled MTF leaders to get to know each other better, which improved cooperation and teamwork between MTF departments.

Captain Reed also strived to empower the MTF staff by allowing subordinates to make decisions, by listening to them, and by recognizing them when they did well. By empowering the MTF staff as opposed to controlling them by authoritarian means, Captain Reed believed that the MTF staff was more likely to do their best. If controlled, personnel tended to focus only on meeting minimum standards.

Captain Reed believed that empowerment without direction equalled chaos. He ensured that subordinates were given direction by clearly stating his values and expectations. The MTF's vision statement and guiding principles also gave the MTF staff a framework in which to make decisions.

One key benefit of decentralizing decision making and providing a framework for subordinates to act was that it placed less reliance on the CO in managing the day-to-day operations. Without worrying about the daily operation of the MTF, the CO could devote more time and energy planning the MTF's future, promoting the MTF to outside groups, and working on special projects.

At the end of Captain Reed's tenure as CO, the MTF directors became accustomed to the decentralized decision

making and the TQL framework. Once given the authority to make decisions, the directors may be unwilling to give up their power. Attempts by Captain Simon to take away the directors' authority would likely be met with resistance.

Captain Simon also faces the difficult task of keeping morale high, especially if Congress decides to close the MTF. Few would want to make further improvements if the MTF were to close. Additionally, concerns over careers, loss of jobs, and declining property values would preoccupy the thoughts of many. As a result, job performance and the quality of care provided may suffer.

V.   SUMMARY STATEMENT

A.   CONCLUSIONS

1.   Primary Research Question

What appropriate leadership styles and actions are necessary to effectively lead and manage military MTFs? As evidenced by Captain Hendrix and Captain Reed, more than one style may be effective. Captain Hendrix's leadership style was characterized as top-down, people oriented, and charismatic. Captain Reed's leadership style was characterized as systems oriented, analytical, and empowering. Despite their differences, both commanding officers were considered outstanding leaders by personnel within the MTF.

Captain Reed and Captain Hendrix also had many similarities. They both were respected in their fields and as leaders. Additionally, they both cared for the welfare of the patients and those under their command. Finally, their personal enthusiasm and confidence was contagious. From their presence alone, everyone knew that they were leaders.

From the case, it becomes evident that appropriate leadership styles and actions are dependent on the situation. Captain Hendrix's top-down approach was effective when quick action was required to end the equal opportunity problem and to restore confidence in the MTF's leadership. Similarly,

Captain Reed's decision to allow the MTF directors to develop the vision statement and strategic goals was appropriate given the situation. The ability of Captain Hendrix and Captain Reed to make quick studies of the situation and take appropriate action contributed to their success.

Another factor which contributed to their success was their ability to capitalize on opportunities when presented. Captain Reed used the crisis of Hurricane Hugo to rally the MTF towards achieving its mission, which increased morale. Likewise, Captain Reed used the DESERT SHIELD crisis to transfer an adversarial XO and establish himself as the MTF's leader. The ability to capitalize on opportunities is another characteristic of effective MTF leaders.

Finally, an MTF leader cannot be everything to everyone at the same time. Instead, effective MTF leaders use their individual strengths to their advantage. Captain Hendrix was a charismatic, people-person. He relied on the strength of his personality to lead others. On the other hand, Captain Reed's expertise was his ability to view the MTF as a system. Consequently, Captain Reed used his ability to coordinate the efforts of others to successfully lead the MTF.

One may be tempted to say the "ideal" CO would be a cross between Captain Hendrix and Captain Reed. Such a combination would yield a charismatic, people-oriented leader with well developed analytical and problems solving abilities. Whether or not the combination would yield the ideal MTF

leader is irrelevant. What is important is that individuals learn from the experiences and actions of Captains Hendrix and Reed. Through study and practice, prospective MTF leaders can develop their own leadership and management skills. The lessons learned from Captain Hendrix and Captain Reed form one part of the education process.

2. Secondary Research Questions

The answer to the secondary research question, managing change and uncertainty caused by military downsizing and health care cost containment, depends on the specific situation. Nevertheless, one of the main problems confronting MTF leaders faced with base closure and downsizing is maintaining high morale and quality. With the threat of closure, MTF staff members become reluctant to expend effort to create improvement. As a result, job satisfaction and morale tend to decrease.

One way to limit the amount of uncertainty due to the base closing process is to keep the MTF informed. Many find the base closing and military downsizing process confusing. Information on the status of the closing process helps dispel rumors which cause unnecessary concern. Additionally, briefs concerning separation, retirement, and moving benefits help ease uncertainty by providing information on available options.

B. FUTURE STUDY

In order to provide additional management education topics and problems solving perspectives, similar case studies could be conducted at other military MTFs. The number and nature of management issues contained in the cases were limited by the scope of this thesis. The management topics covered in this thesis were limited solely to those occurring at the Charleston Naval Hospital from June 1988 to June 1993. Finally, if Congress decides to close the Charleston Naval Hospital in July 1993, this case can be expanded to further develop the issue of base closure and its effects on the MTF.

MANAGING A MILITARY MEDICAL TREATMENT FACILITY:
A SURVEY OF EDUCATIONAL NEEDS

This survey is designed to assess your perception of the knowledge and ability required to effectively manage health care facilities, now and in the future. We will use the results of the survey to design executive management education programs.

The survey is based on the views and beliefs of over 100 Navy Medical Department executive managers, elicited through interviews and a pretesting process. As a result, survey questions represent management knowledge and abilities that were most frequently expressed as necessary for managing medical treatment facilities.

Your responses to this survey will become part of the aggregate of responses from others currently serving in executive management positions throughout the Navy Medical Department. The combined results will allow us to quantify the importance of each management skill area.

All information gathered by this survey will be collated, in the aggregate, for statistical use only. The anonymity of each survey participant is assured since no need exists, and no effort will be made, to identify the participants.

Please do the following:

1.   Follow the instructions provided in the survey.

2.   Complete this survey within five (5) working days.

3.   Return your completed survey in the pre-addressed envelope provided for that purpose.

If you have any questions, contact Adj. Research Professor Ken Orloff at (408) 646-3339 or (DSN) 878-3339.

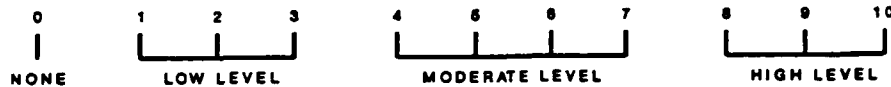**Thank you for your participation.**

MANAGING A MILITARY MEDICAL TREATMENT FACILITY - PART I

This survey has two purposes. It is designed to measure:
1) Your current level of managerial skills.
2) Your perception of the required level of skills for an executive in your role.

Using the scale, rate each of the following managerial activities in terms of your current level of knowledge or ability. A "0" indicates that you have no knowledge or ability in this area. A rating of "1" to "3" indicates a low level of knowledge or ability, a rating of "4" to "7" indicates a moderate level, and a rating of "8" to "10" indicates a high level. Use the numbers within a category to indicate your position more precisely. (Put your ratings in the column labeled "Current Skill Level.")

Then, using the same scale, rate the same managerial activities in terms of the required level of knowledge or ability necessary to function effectively as an executive in your role. (Put your rating in the column labeled "Required Skill Level.")

```
   0         1     2     3        4     5     6     7        8     9     10
   |         |_____|_____|        |_____|_____|_____|        |_____|_____|
 NONE         LOW LEVEL              MODERATE LEVEL             HIGH LEVEL
```

CURRENT SKILL LEVEL	REQUIRED SKILL LEVEL	FINANCIAL/RESOURCE MANAGEMENT
_____	_____	1. Interpreting financial statements, e.g., OPTAR, MEPR, NC2199, etc.
_____	_____	2. Recognizing funding sources and limitations of their uses.
_____	_____	3. Evaluating operating (O&M,N) and capital (OP,N) budgets and monitoring their execution.
_____	_____	4. Knowing the resource management advantages and drawbacks of alternative health care delivery systems.
_____	_____	5. Maximizing benefits from third party payer (e.g., insurance companies) reimbursements.
_____	_____	6. Working with the procurement system (negotiating, contracting, evaluating bids, acquiring goods and services).
_____	_____	7. Understanding cost-benefit analysis techniques (make or buy decisions, cost-effective trade-offs).

PROGRAM PLANNING AND EVALUATION

_____	_____	8. Managing a planning process: using models and methods of both strategic and business planning.
_____	_____	9. Understanding methods for evaluating the effectiveness and efficiency of various programs.
_____	_____	10. Evaluating and applying market analysis strategies, including methods to analyze customer needs.
_____	_____	11. Employing quality improvement principles and methods.

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MANAGING A MILITARY MEDICAL TREATMENT FACILITY - PART I

0	1	2	3	4	5	6	7	8	9	10
NONE		LOW LEVEL			MODERATE LEVEL				HIGH LEVEL	
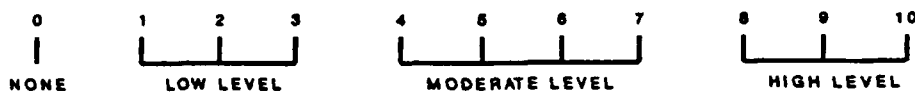
CURRENT SKILL LEVEL   REQUIRED SKILL LEVEL

_____   _____   12. Understanding the interrelationships of departments and functions of military treatment facilities, i.e., the systems perspective.

DECISION MAKING/PROBLEM SOLVING

_____   _____   13. Assessing the quality and usefulness of available information when faced with complex problems.

_____   _____   14. Deciding the extent to which others should be included in decision making.

_____   _____   15. Using decision making techniques/problem solving approaches and methods.

_____   _____   16. Using management information systems technologies to solve complex problems.

_____   _____   17. Using statistical tools in planning and day-to-day decision making.

_____   _____   18. Understanding the strengths and weaknesses of the statistical techniques that comptrollers or quality assurance analysts most often use.

_____   _____   19. Understanding how information systems are designed to meet information needs.

_____   _____   20. Analyzing risks/alternatives.

LEGAL ISSUES

_____   _____   21. Knowing what constitutes a violation of the Uniform Code of Military Justice (UCMJ).

_____   _____   22. Knowing what non-judicial punishments are available under the UCMJ.

_____   _____   23. Initiating appropriate actions for UCMJ violations.

_____   _____   24. Knowing administrative separation authority and procedures.

_____   _____   25. Having a working knowledge of liability, both hospital and professional.

_____   _____   26. Having a working knowledge of environmental impact issues.

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MANAGING A MILITARY MEDICAL TREATMENT FACILITY - PART I

0	1	2	3	4	5	6	7	8	9	10
NONE	LOW LEVEL			MODERATE LEVEL				HIGH LEVEL		

CURRENT SKILL LEVEL	REQUIRED SKILL LEVEL	OPERATIONS MANAGEMENT ISSUES
_____	_____	27. Understanding the impact of OSHA requirements on hospital operations.
_____	_____	28. Evaluating the merit of proposals to acquire new technology.
_____	_____	29. Understanding the opportunities and limitations of the DoD/DoN materials management system.
_____	_____	30. Overseeing equipment management programs.
_____	_____	31. Ensuring proper execution of security requirements for the physical plant.
_____	_____	32. Overseeing facilities management.
		ORGANIZATIONAL BEHAVIOR
_____	_____	33. Understanding the support requirements of the operating forces.
_____	_____	34. Developing and communicating a vision for the command.
_____	_____	35. Empowering individuals and work groups.
_____	_____	36. Developing a non-parochial/"generalist" perspective.
_____	_____	37. Building trust.
_____	_____	38. Managing change.
_____	_____	39. Managing conflict.
_____	_____	40. Building teamwork.
_____	_____	41. Developing a positive organizational climate/culture.
_____	_____	42. Motivating people.
_____	_____	43. Employing coordinating mechanisms (e.g., teams, task forces, ad hoc work groups).
_____	_____	44. Developing subordinates: coaching, teaching, mentoring.

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MANAGING A MILITARY MEDICAL TREATMENT FACILITY - PART I

0	1	2	3	4	5	6	7	8	9	10
NONE	LOW LEVEL			MODERATE LEVEL				HIGH LEVEL		

CURRENT SKILL LEVEL   REQUIRED SKILL LEVEL

_____   _____   45. Understanding the role/scope of the job of CO/XO.

_____   _____   46. Promoting innovation and risk taking behavior.

MANPOWER AND HUMAN RESOURCE MANAGEMENT

_____   _____   47. Managing civilian personnel according to regulations and procedures.

_____   _____   48. Managing military personnel according to regulations and procedures.

_____   _____   49. Evaluating manpower and staffing needs.

_____   _____   50. Managing labor relations (union negotiations, grievances, etc.)

_____   _____   51. Managing multi-cultural diversity in the workplace.

_____   _____   52. Building a climate that promotes ethical practices in clinical and managerial operations.

COMMUNICATION

_____   _____   53. Writing effectively.

_____   _____   54. Giving positive and negative feedback.

_____   _____   55. Delivering effective oral presentations.

_____   _____   56. Listening effectively.

_____   _____   57. Building and maintaining working and support relationships outside your institution.

_____   _____   58. Representing the organization to external groups, e.g., public relations functions.

_____   _____   59. Fostering a climate of open communication.

_____   _____   60. Conducting meetings effectively.

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MANAGING A MILITARY MEDICAL TREATMENT FACILITY - PART I

If a management education program were to be developed for an executive in your role, what level of need would you attach to providing education in each of the following managerial activity groups. Using the scale below, a rating of "1" to "3" indicates a very low level, a rating of "4" to "7" indicates a moderate level, and a rating of "8" to "10" indicates a very high level. Use the numbers within a category to indicate more precisely the level of need.

```
  1       2       3       4       5       6       7       8       9      10
  |_____|_____|       |_____|_____|_____|       |_____|_____|
  VERY LOW PRIORITY           MODERATE PRIORITY              HIGH PRIORITY
```

PRIORITY	MANAGERIAL ACTIVITY GROUPS
_____	Financial/Resource Management
_____	Program Planning and Evaluation
_____	Decision Making/Problem Solving
_____	Legal Issues
_____	Operations Management Issues
_____	Organizational Behavior
_____	Manpower and Human Resource Management
_____	Communication

Please provide below any additional comments you may have.

_____

_____

_____

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_____

MANAGING A MILITARY MEDICAL TREATMENT FACILITY - PART II

In addition to the "managerial skill level" questionnaire you have just completed, please provide the demographic data and management education information requested below.

This information is part of the data collection effort and will be collated, in the aggregate, for statistical use only. The anonymity of each survey participant is assured since no need exists and no effort will be made to identify individuals participating in this survey.

Instructions: Please check only those blocks that apply in your individual case and legibly complete any other information in the underlined spaces provided for that purpose.

(1) **Demographic Data** - blocks involving subspecialty codes should be completed only where codes are formally assigned to you as an individual.

(2) **Management Education/Training** - check only those courses/programs you have successfully completed.

DEMOGRAPHIC DATA

1. Rank: _____

2. Gender: ☐ Male   ☐ Female

3. Designator: ☐ 21xx   ☐ 23xx   ☐ Other _____
                    ☐ 22xx   ☐ 29xx

4. Subspecialties: _____ _____ _____
    (List by code if known)

5. Length of active commissioned service: Years_____   Months_____

6. Degrees completed: ☐ Bachelors - Major _____
                           ☐ Masters   - Major _____
                           ☐ Doctorate - Major _____

7. Current position/title _____

8. Facility Size: Beds (Set-up): _____
                   Outpatient Visits (annual): _____
                   Teaching Hospital: ☐ Yes   ☐ No
                        Family Practice Residency Only ☐ Yes   ☐ No

9. Time served in current position:
    ☐ Less than 6 months   ☐ 6-12 months   ☐ Greater than 36 months
    ☐ 12-24 months   ☐ 24-36 months

10. Total months service (past and present) in Commanding Officer billets: _____
    Total months service (past and present) in Executive Officer billets: _____

11. Years in current geographical location: _____

12. Number of prior managerial positions: _____
    (managerial = >50% of time involved in managerial (non-clinical) tasks)

13. Years service in managerial positions: _____

MANAGEMENT EDUCATION/TRAINING BACKGROUND

DOD Postgraduate Education Programs

- ☐ Armed Forces Staff College
- ☐ Industrial College of the Armed Forces
- ☐ Naval Postgraduate School
    - ☐ Financial Management
    - ☐ Manpower Planning, Training, Analysis
    - ☐ Information Systems Management
    - ☐ Operations Research
    - ☐ Logistics
- ☐ Army-Baylor University
- ☐ Naval War College
    - ☐ Command and Staff
    - ☐ Naval Warfare
- ☐ Marine Corps Command and Staff College
- ☐ Other Intermediate/Senior Service Schools: _____ _____

_____

Other Traditional Undergraduate/Graduate Management Programs

- ☐ MHA
- ☐ MPH
- ☐ MBA
- ☐ BS (HCA)
- ☐ BBA
- ☐ Other _____

Non-Traditional Postgraduate/Executive Management Programs

- ☐ Univ Wisconsin - Madison (MS Admin Medicine)
- ☐ Physicians in Management (PIM) Series, ACPE
- ☐ Management Education for Physicians (MEP), ACMGA
- ☐ Univ North Carolina - Kron Scholar Program
- ☐ Cornell Univ - Health Executives Development Program
- ☐ Johnson & Johnson - Wharton Fellows Program for Nurses
- ☐ Estes Park Institute (annual seminar)
- ☐ Other _____

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MANAGEMENT EDUCATION/TRAINING BACKGROUND (cont)

Service Short Courses
- ☐ Prospective Commanding Officer/Executive Officer
- ☐ Interagency Institute for Federal Health Care Executives
- ☐ Leader Development (LMET)
    - ☐ Command
    - ☐ Senior
    - ☐ Intermediate
- ☐ Strategic Medical Readiness and Contingency
- ☐ Management Development
- ☐ Financial & Material Management
- ☐ Patient Services Administration
- ☐ Plans, Operations and Medical Intelligence
- ☐ Manpower Management
- ☐ Professional Military Comptroller
- ☐ Senior Leaders Seminar (TQL)
- ☐ Other _____

MANAGEMENT CERTIFICATION/ FELLOWSHIP

- ☐ ABMM (Board Certified)

- ☐ ACHE (Fellow)

- ☐ ACMGA (Fellow)

- ☐ ACPE (Fellow)

- ☐ AAMA (Fellow)

- ☐ Other _____

Thank you for your participation in this study. Results will form an integral part of research efforts directed at identifying the knowledge and skills needed to effectively manage health care facilities, now and in the future.

Please return your completed survey (both Parts I & II) in the envelope provided for that purpose to the following address:

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APPENDIX B: QUESTIONS SENT TO CAPTAIN REED

LEADERSHIP IN A MILITARY TREATMENT FACILITY

1. Give us some background as to what the MTF was like when you took command? What were its core Values? Did it have a clear sense of purpose? Was that purpose clearly articulated? What was the state of morale and motivation?

2. What processes did you use before and after your arrival to gather information about the command? In other words, how did you, and, perhaps, others determine the "current reality" of the organization? Did your MSC background cause you to see the organization from a unique perspective?

3. What kind of MTF did you want to paint? In other words, what was your vision for the command?

4. How are strategies developed and implemented to support the vision?

5. Do you believe the vision took hold? Have you used any measures to determine that the vision has been successfully communicated throughout the MTF as well as shared and internalized? Have you devised means to determine if associates (workers) have used the vision to shape their jobs or their attitudes toward those jobs?

6. Describe your leadership/management philosophy.

7. How are people developed here, e.g., training policies, continuing education, mentoring, etc.?

8. How are decisions made? Examples?

9. Is the team concept employed in your organization? If so, to what extent? If teams are employed, to what extent are team members empowered to make decisions. What kind/type of decisions can they make?

10. Describe motivation in this organization, e.g., extrinsic, intrinsic, reward systems, etc.

11. What are the issues of concern in this organization right now?

12. What issues do you anticipate will be of concern in the future? How do you determine what's going to be important in the future?

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APPENDIX C: TYPICAL NAVY MTF CHAIN OF COMMAND

THE NAVY MEDICAL DEPARTMENT

```
                                                    PRIMARY
                                                      AND
                                                    TECHNICAL
                                                     SUPPORT

                         CHIEF                                    ┌──────────────┐
                          OF                                      │    CHIEF     │──── HEALTHCARE
                         NAVAL                                    │    BUMED     │       STANDARDS
                       OPERATIONS                                 │              │──── CHAMPUS
                                                                  └──────────────┘──── CATCHMENT
                                                                                          AREA
                                                                                        PLANNING

                                           ┌──────────────┐
                                           │  HEALTHCARE  │──── RESOURCES
                                           │   SUPPORT    │──── MANAGEMENT
                                           │   OFFICES    │      INFORMATION
                                           │              │      SYSTEMS
                                           └──────────────┘──── TECHNICAL
                                                                 ASSISTANCE

        STAFF
       AUGMENT
                    ADDITIONAL DUTY

  MILITARY        ┌──────────────┐
  COMMAND         │  ECHELON II  │
                  │  COMMANDER   │

                  ┌──────────────┐
                  │ RESPONSIBLE  │
                  │     LINE     │
                  │  COMMANDER   │

                  ┌──────────────┐
                  │   MEDICAL    │
                  │    DENTAL    │
                  │  FACILITIES  │
                  └──────────────┘
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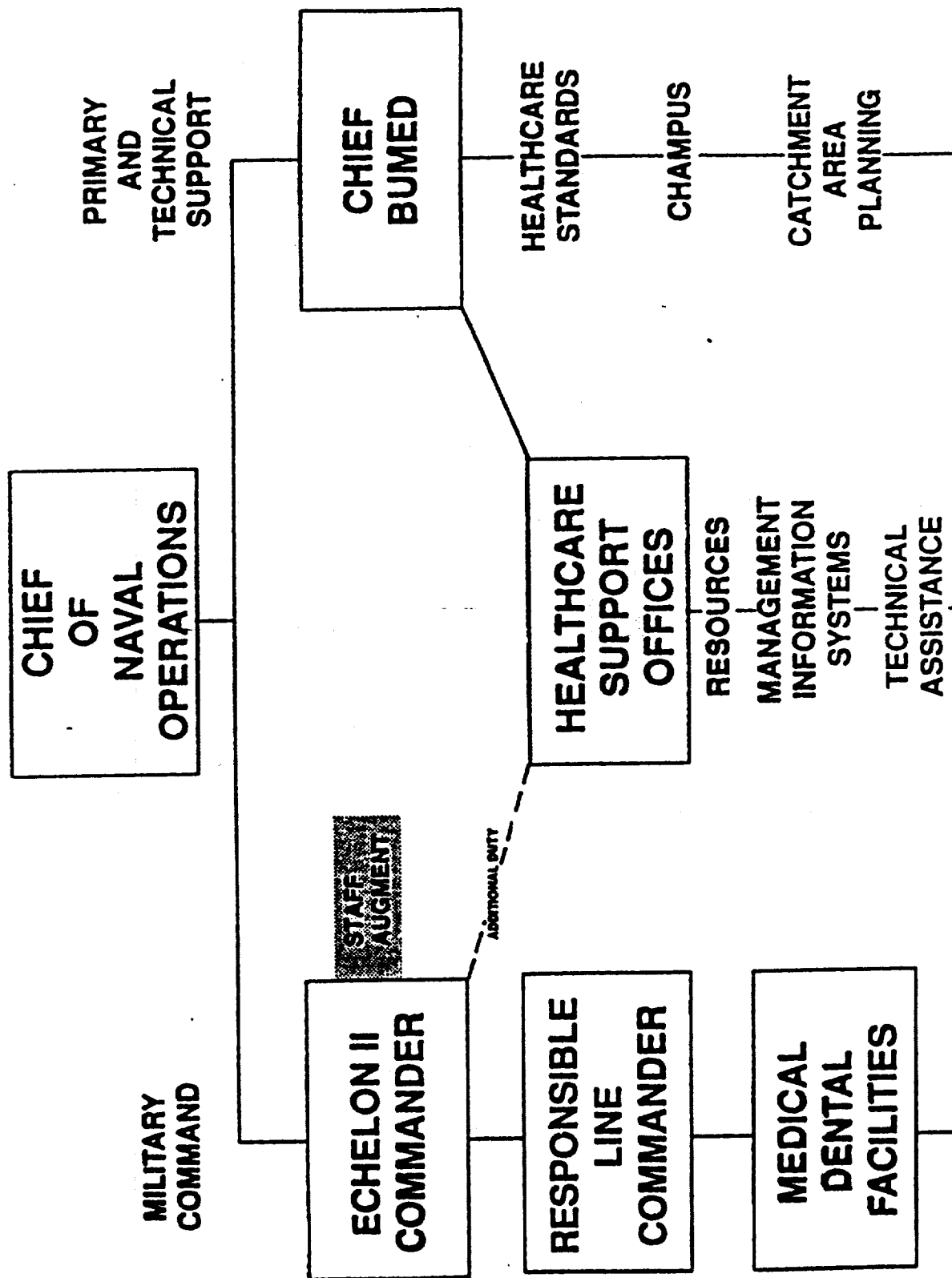
APPENDIX E: DESCRIPTION OF MTF DIRECTORATES

Director For Administration

The Administration Directorate (Code 01) performed a myriad of administrative tasks for the CO and staff at the MTF including the management of hospital finance, manpower, management information systems, and facilities operation. Under the Director of Administration came eleven major functions each headed by a department head. The Director of Administration served as the COs primary staff advisor on all matters pertaining to:

- hospital inpatient/outpatient administration
- operations management
- civilian personnel administration
- materials management
- food service management
- morale-welfare-recreation programs
- education training
- legal.

Close coordination between the Director of Administration and other MTF directors was necessary since the many administration departments provided functional assistance to all other directorates.

Director for Nursing Services

The Nursing Directorate (Code 02) was responsible for the coordination and efficient operation of all nursing matters. Since the majority of the nurse staff supported clinicians in various medical departments (i.e. surgery, ambulatory care, operating rooms, maternity ward, etc.) cooperation between the Director of Nursing and the directors of clinical areas was essential for effective utilization of nurse staff.

Director for Medical Services

The Directorate for Medical Services (Code 03) was responsible for the coordination and efficient operation of all medical matters. Included in the Medical Services Directorate were:

- internal medicine
- dermatology
- mental health
- EAMC
- emergency care
- family practice
- pediatrics
- optometry
- operation of the branch medical clinics.

The Director for Medical Services was directly responsible for quality of all inpatient and ambulatory care within the designated medical services of the MTF. To provide the

quality care, staff support from nursing, administration, and ancillary services was required.

Director for Surgical Services

The Directorate for Surgical Services (Code 04) was responsible for surgical services in the MTF. Included in the Surgical Services Directorate were orthopedics, orthalamolgy, otorhinolaryngology, OB/GYN, urology, anesthesiology, PT/OT, and dental services. Staff support from administration, medical services, nursing, and ancillary services was required to provide quality surgical care.

Director for Ancillary Services

The Director for Ancillary Services (Code 05) was responsible for all ancillary services such as laboratory, radiology, pharmacy, and social work. The Ancillary Services Directorate provided essential services for the other clinical directorates.

Director for Occupational Health

The Director of Occupational Health (Code 06) provided support and training in the areas of preventative medicine, radiation health, occupational health, and industrial hygiene to other MTF directorates and to the fleet.

Director for Strategic Planning

The Directorate for Strategic Planning (DSP) (Code 07) was implemented in 1990 and was tasked with data administration, optimization of health care expenditures and access to services within the catchment area, and the assessment proposed projects. The DSP assisted in the formulation of the command's strategic plan and in the monitoring of progress toward achieving goals and objectives. The DSP was set up so the MTF could better manage the CAM demonstration and to better use health care cost and access data in decision making.

APPENDIX F: DESCRIPTION OF STANDING COMMITTEES

The following represent required committees and other standing committees as appointed by the commanding officer and required by BUMED directives to maintain standards for graduate training, to meet standards for accreditation set by the JCAHO, to conform to the requirements of law or regulations, and to advise the commanding officer on matters of policy or particular interest.

1. <u>Accreditation Committee</u>. The Accreditation Committee shall be an inter-disciplinary committee chaired by the Executive Officer to keep the clinical, nursing and administrative staffs abreast of all developments in the Joint Commission on Accreditation of Health Care Organizations Accreditation Program and to keep the entire staff informed regarding the accreditation status of the hospital. The committee shall meet as needed, but at least quarterly and shall have prepared minutes for submission to the Commanding Officer.

2. <u>Bioethics Review Committee</u>. The committee provides guidance to the Commanding Officer and staff concerning treatment decisions having ethical implications. The committee has specific responsibility for review of cases involving "Do Not Resuscitate" orders written by physicians. The committee shall meet as needed and report recommendations to the Commanding Officer via the Executive Committee of the Medical Staff.

3. <u>Cardiac Arrest Committee</u>. The committee is responsible for standardizing equipment and procedures for dealing with cardiac arrests. The committee will meet at least quarterly and report its actions and recommendations to the Commanding Officer via the Executive Committee of the Medical Staff.

4. <u>Command Assessment Team</u>. The Command Assessment Team shall discuss issues that are brought to their attention related to the improving of communications and morale within the Command. It shall solicit constructive effectiveness of the Command's Equal Opportunity Program and the Command Assessment Team shall be assisted by: The Menu Review Board, the MWR Committee and the Unaccompanied Personal Housing Advisory Committee. The team shall meet as needed but at least quarterly and prepare minutes with subcommittee minutes as enclosures for submission to the Executive Officer.

5. <u>Command Education Committee</u>. The Command Education Committee shall be mandated to formulate, oversee and coordinate the overall education and training activities of the staff members within the hospital. The committee shall meet monthly and prepare minutes for submission to the Commanding Officer.

6. <u>Controlled Medicinal Inventory Board</u>. The Controlled Medicinal Inventory Board is established to provide a "check and balance" for accountability and handling of controlled substances. The duties of the board include, but are not limited to, review of all accounting records and transactions, adjust inventory balances and reconcile monthly Naval Medical Material Support Command reports with local receipt documents.

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7. **Credentials Committee**. The Credentials Committee shall provide the standard method for the evaluation, granting, renewal, revocation and curtailment of clinical privileges of the medical staff and other health care professionals rendering direct patient care on the basis of independent judgment.

8. **Disaster Preparedness Committee**. The Disaster Preparedness Committee shall develop and continually evaluate a set of disaster preparedness plans for the hospital. These plans shall include plans for contingencies of aircraft accident, mass casualty, fire within the hospital, bomb threats, radioactive contamination incidents, major chemical contamination incidents, and other such natural disasters as may affect the hospital. The committee shall conduct and evaluate disaster preparedness exercise and shall continually evaluate the plan, procedures, patient flow, record keeping, personnel assignments, logistic support, transportation, evacuation, recall, and other such matters as may be necessary to operate the Command in a contingency situation. This committee shall meet as needed, but at least quarterly, and prepare minutes for submission to the Executive Committee.

9. **Discharge Planning Team (DPT)**. The DPT facilitates a patient's discharge as soon as an acute level of care is no longer required and assures appropriate allocation of the facilities resources. The DPT meets weekly and reports monthly to the Utilization Review Coordinator via the Quality Improvement Coordinator.

10. **Energy Conservation and Resources Management Committee**. The Energy Conservation and Resources Management Committee shall develop and insure implementation of a facility energy reduction plan. The plan shall cover such elements as creating energy awareness among staff members, the recommending and monitoring of immediate energy conserving actions and the development of long range capital improvement energy conserving actions and the development of long range capital improvement energy conserving projects. The committee shall meet as needed, but at least quarterly, and shall prepare minutes for submission to the Executive Committee.

11. **Equal Opportunity Employment/Federal Women's Program Committee**. The EEO/FWP Committee is composed of EEO Officials and members. The Committee serve to provide a channel of communication between management and employees on EEO/FWP matters. The committee undertake specific studies as requested or determined appropriate to identify potential problem areas and to make recommendations for affirmative action to be taken to promote equal employment opportunities and practices. All formal recommendations and reports of findings on specific studies will be made to the Commanding Officer via Deputy EEO Officer. The committee provides special emphasis programs for awareness throughout the fiscal year.

12. **Executive Committee of the Governing Body**

    a. Membership Commanding Officer, Executive Officer, Directorates, and the chairman of the executive committee of the medical staff.

    b. Chairman: Commanding Officer

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c. Responsibilities:

   (1) Consideration and submission of recommendations to the commanding
officer for action on all matters of a medical-administrative nature.

   (2) Implementation of policies approved by the commanding officer.

   (3) Ensuring ethical conduct of staff members and initiating
appropriate corrective measures.

   (4) Reporting accountability for health care rendered to patients.

   (5) Keeping the clinical and administrative staffs abreast of the
JCAHO accreditation program and informed of the accreditation status of the
hospital.

   (6) Serves as the committee for communications other than graduate
training, when established, between the commanding officer and the clinical
and administrative staff of the command.

13. Executive Committee of Medical Staff

   a. Membership: Designated members of the medical staff.

   b. Chairman: Appointed by the commanding officer.

   c. Responsibilities:

   (1) Receives and acts upon reports and recommendations from medical
staff committees, departments, services, and other assigned activity groups.

   (2) Implements approved policies of medical staff.

   (3) Recommends to the commanding officer on all matters related to
medical staff.

   (4) Fulfills the medical staff's accountability to the commanding
officer for quality of medical care rendered to patients.

   (5) Initiates and pursues corrective action, when warranted, in
accordance with medical staff bylaws provisions.

   (6) Participates in the accreditation process and informs the medical
staff of the JCAHO accreditation program and accreditation status of the
hospital.

14. Family Advocacy Committee. The Family Advocacy Committee shall design,
monitor and evaluate a program to include the identification, evaluation,
interaction, treatment, and prevention of child abuse, child neglect, spouse
abuse, sexual assault, rape, and other such disruptive patterns in accordance

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with the directives of the Bureau of Medicine and Surgery. The Child
Abuse/Neglect Committee and the Spouse Abuse/Neglect/Sexual Assault Committee
shall meet monthly, and the Family Advocacy Committee at least quarterly, and
prepare minutes for submission to the Executive Committee.

15. Graduate Medical Education Committee

    a. Membership: Heads of departments having direct involvement in GME.
Branch heads with approved residency and fellowship programs, head of intern
training, and head of clerkship training (medical students).

    b. Chairman: Executive Officer.

    c. Responsibilities: Function as the commanding officer's board of
trustees or board of regents for the graduate training programs.

16. Health Care Consumers Council. The Health Care Consumers Council shall
provide a regular forum for health care deliverers and consumer
representatives to exchange information and ideas that will contribute to a
better understanding and utilization of health care resources. The council
shall meet as needed, but at least quarterly, and shall prepare minutes for
submission to the Executive Committee.

17. Infection Control Committee. The Infection Control Committee shall be a
multidisciplinary committee devoted to the study of infections acquired by
patients and staff within the hospital. It shall establish uniform procedures
for recording acquired infections. It shall monitor remedial actions taken,
and act as a primary advisor to the Commanding Officer for all matters
regarding infection control within the command. The committee shall meet
bimonthly and shall prepare minutes for submission to the Executive Committee
via the Quality Improvement Coordinator.

18. Information Systems Executive Board. The Information Systems Executive
Board is a multidisciplinary committee devoted to the analysis of current and
future Information Systems to ensure cost feasibility, effective utilization
of resources and compliance with current Information System directives. The
ISEB meets monthly when feasible, but not less than once per quarter.

19. Invasive Procedures and Transfusion Committee.. The Tissue and Transfusion
committee shall review and evaluate all surgery performed in the hospital
based upon the analysis of preoperative and postoperative diagnosis,
indications of surgery, and the actual diagnosis on all tissue removed. The
committee shall evaluate all surgical procedures in which no specimen was
removed. The Committee will review and monitor the use of blood and blood
products and review all transfusion reactions. The committee shall function
as a consulting body to the entire medical staff. While recommendations of
the board are advisory and not binding, treatment contrary to the board's
recommendation shall not be instituted without the express approval of the
Commanding Officer. The Committee shall meet monthly and prepare minutes for
submission to the Executive Committee via the Quality Improvement Coordinator.

20. <u>Linen Management Committee</u>. The Linen Committee will establish and continually monitor a Linen Management Program keeping the Commanding Officer advised of such matters as are necessary. The committee shall establish and periodically review bacteriological control and testing standards for the handling and processing linen and recommend changes in policy and procedures involving linen control distribution. The committee shall meet as needed, but at least quarterly, and prepare minutes for submission to the Executive Committee.

21. <u>Medical Library Committee</u>. The Medical Library Committee shall oversee the operation of the Medical Library, screen requests for the procurement of books, periodicals, journals and other communication media and ensure that the needs of both staff development and patient education programs. This committee shall meet as needed, but at least quarterly and prepare minutes for submission to the Commanding Officer.

22. <u>Medical Records Review Committee</u>. The Medical Records Review Committee is established to provide supervision over the timely completion, clinical pertinence and overall adequacy of medical records. The duties of the committee include, but are not limited to, determine medical record format, approve medical record forms, ensure command compliance with current directives regarding medical record keeping procedures, determine criteria for medical record review and recommend incomplete medical records for retirement. The Committee meets at least monthly and reports at least monthly to the Executive Committee of the Medical Staff via the Quality Improvement Coordinator.

23. <u>Occupational Safety and Health Committee</u>. Subordinate to the Occupational Safety and Health Council, the committee is charged with investigating and resolving safety issues having broad application across departmental lines, recommending improvements in current processes to he council.

24. <u>Occupational Safety and Health Council</u>. The Occupational Safety and Health Council is chaired by the Executive Officer and reports directly to the Commanding Officer. The council is charged with considering command wide policy and overall management of the OSH program.

25. <u>Pharmacy and Therapeutics Committee</u>. The Pharmacy and Therapeutics Committee shall act as an advisory group on matters pertaining to the selection of formulary drugs, the evaluation and development of the formulary systems, and the utilization of nonstandard drugs within the hospital. The committee shall review and monitor the drugs stocked and used within the institution and shall make recommendations regarding standing drug orders, automatic stop orders, specific doses, or the number of does on specific controlled items. The committee shall meet monthly and shall prepare minutes for submission to the Executive Committee, via the Quality Improvement Coordinator.

26. <u>Physical Security Review Committee</u>. The Physical Security Review Committee will establish and continually review policies and procedures for the maintenance of physical security of the assets and personnel of the command. This committee shall meet as needed, but at least quarterly, and prepare minutes for submission to the Commanding Officer.

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27. <u>Position Management Committee</u>. The Position Management Committee shall assist the Commanding Officer in insuring that the optimum use of all manpower resources is achieved, utilizing various methods, i.e., Internal Review and workload to make its determinations. The committee shall evaluate all requests for staff changes and shall make recommendations as to appropriate increases, decreases and lateral movements of personnel. The committee shall meet as needed, but at least quarterly, and shall prepare minutes for submission to the Executive Committee.

28. <u>Quality Improvement/Risk Management Committee</u>. The Quality Improvement/Risk Management Committee shall monitor and measure the quality of professional care rendered to patients by the medical staff and other health care professionals to meet the requirements of the Joint Commission on Accreditation of Healthcare Organizations. The various aspects of a comprehensive Quality Improvement/Risk Management Program must be combined into a single viable and cohesive system. This system shall be controlled and monitored through the Quality Improvement/Risk Management Committee. The committee shall meet monthly and shall prepare minutes for submission to the Commanding Officer.

29. <u>Radiation Safety Committee</u>. The Radiation Safety Committee is an integral part of the Command's Radiation Safety program, established to ensure that individual and collective doses of ionizing radiation are as low as reasonably achievable. The committee meets as often as necessary, but not less than quarterly.

30. <u>Recreation Council/Menu Review Board/Unaccompanied Personnel Housing Advisory Committee</u>. These boards, councils and committees shall meet, discuss and make recommendations on issues and possible improvements relative to their respective areas of concern. Each shall meet monthly and shall prepare minutes for submission to the Executive Officer with copies to the Command Assessment Team.

31. <u>Space Utilization Committee</u>. The Space Utilization Committee shall study current utilization of space, consider and make recommendations in response to requests for additional space and/or reassignment or relocations and shall develop a Space Utilization Plan, insuring the most efficient and energy conserving use of space, for the next five years and update annually. The committee shall meet as needed, but at least quarterly, and shall prepare minutes for submission to the Executive Officer.

32. <u>Special Care Committee</u>. The Critical Care (ICU/CCU) committee shall act as a multidisciplinary committee of the medical and nursing staff to review and evaluate the quality, safety and appropriateness of care provided in the intensive care and coronary care units. The committee shall meet quarterly and shall prepare minutes for submission to the Executive Committee via the Quality Improvement Coordinator.

APPENDIX G: CAPTAIN REED'S FITNESS REPORT MEMORANDUM

MEMORANDUM

From: Commanding Officer

Subj: FITNESS REPORT FINESSE

Encl:　(1) Performance Review
　　　(2) Competencies of Navy Medical Department CO's
　　　(3) Sample Fitness Report Writeup
　　　(4) Competencies of Intermediate-Level Medical Department
　　　　　Officers
　　　(5) Suggested Reading

1. In getting ready for my first cycle of fitness reports, I want to pass on to you some of my thoughts and suggestions on how to produce effective reports of personnel performance. Nothing impacts more on an individual's career than a report of that officer's fitness, or that petty officers performance. Therefore, for the benefit of the Navy, the Command, and the individual, I request that you plan ahead to allow adequate and thoughtful time for preparation of the reports.

2. First in order of preparation, the reporting senior (not the CO in this instance) should begin about six months prior to the actual fitness report due date by making an assessment of the subordinates performance. Directors, Department Heads and Division Heads are encouraged to use **"mock fitness reports"** in counseling subordinates concerning their performance. I would suggest that the "mock report" be filled out according to the book, that is; fill it out comparing the subordinate to every officer or petty officer you have ever met. They need to know exactly where they stand in proportion to their peers, and the current system of inflation to the Left, Top 1%, does not really do that. It also is not fair to the really outstanding performer to lump them into a pack of 10 or 15 officers in the far left of the scale. **Performance can not improve if the Rater is not willing to provide true constructive criticism to the Junior.** Another suggested technique would be to use the work sheet, NAVPERS 1611/1W or NAVPERS 1616/24, as a counseling tool. You can make all of your comments on this work sheet and make a comparison periodically looking for improvement. All of these "mock reports" should be kept in your own personal counseling files to assist in making an accurate assessment of performance and improvement when the real report becomes due. My desire is that all military members be given a fair opportunity to grow and improve their performance.

3. The Navy contracted with McBer and Company to study the characteristics that distinguished superior performers from the average performers in specific situations. Those characteristics, or competencies, are now being taught in Medical Department Leadership, Management, Education and Training courses. I believe that using these competencies provides the basis of a good method for evaluating Navy Medical Department officers and they offer an "outline" for composing the write up of fitness reports. This can be of major assistance now that the word is out to use a "bulletized" format for the report write up. For example, enclosure (1) is a performance review of a fictitious CDR Gormley. As the Commander's next assignment, you believe he would be a good Executive Officer and you want to write an evaluation that will meet the goal of giving him the best shot at the opportunity. This performance review could be

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considered the equivalent of the input you would receive on a "brag sheet" from the officer. On the surface it may not be all that impressive. Enclosure (2) is a brief summary of the competencies and behavior patterns of an outstanding Navy Medical Department Commanding Officer. Enclosure (3) is a fitness report write up taking the performance input of enclosure (1) and grouping it under the competencies of enclosure (2). This fitness report was judged to be the best report written at the LMET class that I attended. It was judged by PCOs and PXOs, who are now COs and XOs of many of the Navy's Medical Commands. In addition, many of these officers had previously sat as members, or recorders, of selection boards. Therefore, due to their experience, and not because I drafted the write up, I consider them to be excellent judges. I have provided a similar memorandum with these enclosures to individuals at other commands and they have found this concept to be quite useful in helping to counsel the rated officer in addition to preparing the write up.

4. Enclosure (4) is a listing of the competencies and behaviors of intermediate-level Navy Medical Department officers. **Since the wave of the future is to seek out individuals with these competencies, I believe we can benefit the individual and the Navy Medical Department by evaluating officers in light of these competencies.** We owe it to the Navy and the individual to see that the best among the best are promoted to positions of higher responsibility, and it would be tragic if outstanding officers were passed over due to a less than adequate job in the preparation of the report. In addition, all officers should realize that evaluators and drafters of reports cannot create a **work of fiction.** It is up to the individual officer to provide adequate input to the evaluator for inclusion in the fitness report. I know that it is difficult for professional people to brag about their performance and in some instances some other people may believe that their superior in the chain of command should already know how great they are. But in most instances your superiors do not know all the details. You need to provide them the facts and especially the results of your efforts. These competencies may also help you when you provide the input to your next fitness report.

5. These same principles can also be applied to enlisted evaluations. In fact, you could use the competencies in enclosure (4) as a work sheet since many of the same behavior patterns and skills are required of our petty officers. The same care and thought should given to preparing these evaluations as you would give to preparing input for your own.

6. As far as procedure is concerned, the draft report that you prepare may change as it works its way up the chain of command. In fact, it doesn't hurt to have them prepared and turned in early so that they can be given proper review and consideration. It is the job of the Director, Department Head or Division Head as appropriate to review the final fitness report or evaluation with the rated officer or enlisted person and make suggestions for continued improvement. If the evaluation or fitness report has been altered significantly, then I would suggest an appointment be made with the appropriate Director or Executive Officer to discuss the report, preferably before being signed by the Commanding Officer. If you are still not satisfied with the rationale behind the changes in the marks or the write up, whether they are for the good or the bad, then an appointment with the Commanding Officer is needed. Once the fitness report has been signed you as a Department Head or Division Officer or Leading Chief are expected to support the Commanding Officer's decision. After all, it is **my** report on the fitness of the officer to serve in the Navy and in what capacity. I desire that all individuals capable of being promoted to the next higher rank/grade are given an evaluation/fitness report that will get them promoted. **However, I also realize my responsibility to the Navy to attempt to differentiate and identify the best of the truly outstanding people at this command.** Not everyone will get all "A's, Top 1%, recommended for early promotion"; or recommended for command, executive officer, or officer in charge positions. It is also a fact of life, that not

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everyone is promotable to Chief Petty Officer, Senior Chief Petty Officer, Commander and Captain and not all Commanders and Captains are executive officer or commanding officer material.

7. **What does it take to be a top 1%, early promote?** That is a difficult question but I'll give you my view. First, it certainly varies by Corps and by command. Each Corps has it's own unwritten set of guidelines that appear to change somewhat over time given the personality of the Corps chief and service environment. I tend to trust my senior officer in the Corps to make an assessment of this changing environment and advise me. Second, the job that a person has in the command also has a bearing on consideration for a top 1%, early promote. I know that people are told to do the best they can in the job they are in and the top 1%, early promotes will come. Well, that sounds good, especially since in most instances we don't have much choice in the jobs we are assigned. However, in all candor, this command has a lot of high visibility and high risk programs where failure could be considered a CLM (Career Limiting Move). An individual who is in one of those high risk, high visibility jobs and does exceptionally well, stands a better chance of an early promote recommendation than a person who does well in a job that is not so risky. Third, a person who is a well rounded Naval Officer in addition to being an excellent nurse, physician or ancillary provider also has a better chance for consideration as a top 1%, early promote. Fourth, a top 1%, early promote performer is on board with the Quality Assurance Program and performs their administrative duties with as much skill as their clinical duties. Now you know where I stand.

8. Please review the enclosures to this memorandum and put forth your best effort in preparing performance evaluations. If you have any questions concerning this memorandum or the philosophy behind these procedures, please come by and let's talk about it. One other item that I consider to be important is that I want fitness reports in ON TIME. We all know when they are due, so there is really no reason they can not be done on time. Plan ahead.

CAPT   USN

Distribution:
All Officers and Chief Petty Officers

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PERFORMANCE REVIEW
CDR GORMLEY

1. I got most of my reports in on time. They have been accurate.

2. Overtime spent on projects when they require it.

3. Two subordinates' performance ratings show improvement since they started to work for me. They appear to respect my leadership.

4. I present a good image:
    Neatly dressed.
    Runs 40 miles per week; competes in 10K races.
    Represented the command at the Red Cross volunteers' luncheon.
    Cited by the Commander Naval Base for public speaking efforts at
professional societies.

5. Involved with family: two children, ages six and eight. Entertained hospital and base personnel at two parties this year. Have attended and supported all command fuctions such as Dining In and Dining Out.

6. In charge of facilities committee. Avoided the political hassels that go with the job. Managed to get two departments to accept smaller spaces amicably. Initiatives from the committee have resulted in better-looking clinic areas, grounds, and more pleasant ward lounges.

7. I participate in the patient quality-assurance evaluations at morning reports. I advise the chairman of the Command Quality Assurance/Risk Management Program. The committee has had good results this year.

8. Conducted training in patient management and intensive care.

9. IG Assist Visit/Inspection pointed to my areas and cited them as, "Best I have seen".

10. I attempt to be direct in talking with people and I have been trusted with complicated tasks. I try to present a pleasant attitude.

11. I filled in for XO when he was on leave.

Enclosure(1)

NAVY MEDICAL COMMANDING OFFICER COMPETENCY MODEL

CONCERN FOR SERVICE QUALITY GROUP

1. Attention to Patient Satisfaction
   a. Reads and responds to letters of complaint
   b. Speaks to patients to monitor satisfaction
   c. Uses (makes use of) patient-satisfaction survey
   d. Makes explicit policy statements about being courteous to patients.
2. Concern for Others in Command
   a. Takes steps to demonstrate concern for staff
   b. Acts to respond to staff needs
   c. Anticipates needs of staff.

PERFORMANCE OF COMMAND GROUP

3. Commitment to Improvement
   a. Identifies discrepancies between ideal and existing states
   b. Plans action steps to accomplish objectives (e.g., new programs)
   c. Identifies obstacles and develops contingency plans to deal with them.
4. Sets Clear Performance Goals and Objectives
   a. Specifies particular outcomes being sought
   b. Specifies time frame for accomplishments
   c. Sets expectations for subordinates' performance
   d. Sets and maintains standards of performance and behavior for staff.
5. Efficiency
   a. Recommends more efficient use of manpower
   b. Plans for maximum efficiency and productivity
   c. Takes action to maximize use of time, space, and other resources
   d. Acts to optimize job/person match
   e. Gives subordinates authority and other resources to accomplish stated goals (i.e., delegates authority in order to get the job done).
6. Monitors Performance Against Standards
   a. Monitors individual performance
   b. Monitors command performance (i.e., productivity indices)
   c. Keeps track of professional credentials.
7. Gives Performance Feedback
   a. Confronts others about inadequate or unsatisfactory performance or behavior
   b. Criticizes specific performance on tasks, not the individual
   c. Gives specific, positive feedback concerning performance
   d. Provides medals or other awards for performance

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NAVY MEDICAL COMMANDING OFFICER COMPETENCY MODEL

DIAGNOSTIC ORIENTATION GROUP

8. _Information Gathering_
   a. Asks questions, collects information to understand complaints of others
   b. Receives daily reports to keep abreast of developments in the command
   c. Walks around, makes rounds to find out "what's going on" in the command (focus is on staff)
   d. Seeks information in order to plan for change
   e. Seeks information from multiple sources to deal with immediate need.

9. _Cause-and-Effect Reasoning_
   a. Considers alternatives before making decisions
   b. Considers consequences of actions in advance of taking action
   c. Identifies second-order benefits or problems resulting from a situation (i.e., multiple or long-range consequences that weren't anticipated).

INFLUENCE GROUP

10. _Uses Influence Strategies_
    a. Plans arguments and/or tailors presentations to fit the audience and objective
    b. Attempts to persuade others by appealing to their self-interest
    c. Sells ideas by involving others in the decision-making process as an explicit strategy.

11. _Pushes the System_
    a. Uses contacts outside chain of command to accomplish objectives
    b. Takes repeated actions (efforts) to accomplish a task or to attain resources in the face of obstacles
    c. Takes calculated risks.

IMAGE OF COMMAND GROUP

12. _Concern for Image of Command_
    a. Sees personal appearance or behavior of self/staff as reflecting on command
    b. Makes specific effort to tell others of command mission or philosophy
    c. Explicitly recognizes that command image is affected by patients' perception of the quality of care

13. _Concern for the Values of the Organization_
    a. Demonstrates concern for equity
    b. States an understanding of impact of command actions on individuals.

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NAVY MEDICAL COMMANDING OFFICER COMPETENCY MODEL

REPRESENTATION OF COMMAND GROUP

14. Supports the Fleet
    a. Gives high priority to fleet requests and ongoing programs
    b. Initiates programs that give highest priority to fleet
    c. Explains the specific links between health care and combat readiness.

15. Public Relations
    a. States or acknowledges the importance of holding or initiating meetings with others as representative of command (i.e., with press, public officials, joint services committees, and the line)
    b. Spends time being visible to Navy communities (i.e., building networks)
    c. Participates in community, charitable, or social activities
    d. States awareness of necessity to build ties and networks with a variety of communities.

(Taken from NSHS Command LMET Course, April 1986)

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CDR Gormley is ready for the challenge of Command Responsibility. He has successfully been an acting Executive Officer. His readiness for XO is demonstrated by the following:

o   He is committed to quality patient care.
   -   Major player in the Quality Assurance/Risk Management Program
   -   Eagerly participates in quality assurance evaluations during morning reports. As a direct result of his personal efforts, the Committee has been very successful this year.

o   He sets clear goals and objectives to improve the functioning of his Department.
   -   His department was cited by the IG as the "Best I Have Seen".
   -   He is my primary staff officer for complicated tasks, which require logical, methodical action.

o   He is committed to improving the image of the Hospital in the surrounding area.
   -   As Chairperson of the Facilities Committee, he orchestrated the beautification of the Hospital grounds, clinic area, and ward lounges.
   -   He was personally commended by the Base Commander for his public speaking efforts at professional societies.
   -   He was chosen to represent the Hospital at a Red Cross volunteer luncheon.

o   CDR Gormley is dedicated to the professional development of the officers and staff who work for him.
   -   He is a good role model. He is physically fit, looks sharp, is productive, and often works overtime to get important jobs done.
   -   He establishes clear standards of professional and military performance and provides feedback to subordinates. Two marginal performers improved immeasurably since coming under his direction.
   -   He conducts training in patient management and intensive care.

o   He is excellent in human relations and influencing others to work harmoniously.
   -   As Facilities Committee Chairperson, he anticipated problems and took actions to prevent them.
   -   As part of this effort, he was able to influence two department heads to amicably accept smaller spaces for their departments as an efficiency move.
   -   He and his wife have both contributed to improving morale among the staff and the intergration of hospital and base personnel by sponsoring social activities and supporting command functions.

CDR Gormley has successfully demonstrated his ability to perform in a position of increased responsiblity. He will be a very good Executive Officer. He is ready NOW for promotion to Captain. I would gladly have him as my own Executive Officer!

Note: This write up is based upon the exercise given in the course. Normally, the first paragraph will also include some comments about the persons position and responsiblity in the command, and their attributes and performance. If I were writing this report on an "early promote" I would start the write up with a comment concerning the persons promotablity. I don't want a board member to have to read all the way to the end of the write up to find out if I'm recommending this person for early promotion. **For Example: "Cdr Gormley has my STRONGEST RECOMMENDATION for EARLY promotion to CAPTAIN. He is without a doubt one of the best officers to have worked for me. His potential in the Navy is UNLIMITED."** A statement such as this will get the board members attention and he/she will want to read the whole thing to find out why this person is so great. Of course if the writeup doesn't support the first statement then you've shot your own reputation in the foot,--- So it has to be supported. 123

FITNESS REPORT
TYPICAL LT, MSC, USN

During this short 6 month reporting period, LT Xxxxx has impressed me as an exceptionally competent junior Medical Service Corps Officer. He is an absolutely top notch performer who has recently been frocked to Lieutenant and assigned as the Quality Assurance Coordinator. He is transitioning into this highly visible, high risk, non traditional Healthcare Administration position extremly well. He has achieved the following during this period:

* Goal Setting and Achievement.

    o One of his most important, and time consumming, achievements was as a member of the JCAHO preparation team. He was instrumental in this command's plans and actions which resulted in a full, three year accreditation by the JCAHO. This accreditation was achieved with only 1 Type One recommendations! Not many Naval Hospitals can match this record of performance.

    o Assisted with the review of all instructions relevant to QA and Credentials programs to ensure that they were in compliance with Navy and JCAHO standards.

    o Assisted with the logistical arrangements for the JCAHO surveyors visit to NAVHOSP Timbucktoo.

    o Directed and provided oversight in the development of a more comprehensive, statistical based Risk Management Quarterly Report.

    o Holds weekly meetings, as needed, with investigating officers, command legal officer, and JAG officer from NLSO to discuss progress on command JAG Manual investigations. These meetings result in more complete and better staffed investigations and First Endorsements.

    o Provided a QA oversight assist visit to the Naval Station Branch Medical Annex and to the Branch Medical Clinic at NAF Anywhere.

    o Designed changes to the command's occurrence routing scheme to include more QA Physician Advisor involvment and department participation.

* Subordinant Management and Professional Development.

    o Attended courses on "Civilian Performance Appraisal" and "Counselling and Feedback".

    o Held meetings with all of his civilian employees and rewrote with them their job performance standards. This resulted in the employees having particpation and input into the evaluation process and was well received by them.

    o Works with his employees to refine their data abstraction and analysis techniques which results in their ability to provide more useful reports based on statistical data.

    o Attended the Univ. of Oklahoma completing a course in Business Statistics.

    o Attended the Navy's Quality Assurance/Risk Management Seminar.

LT Xxxxx requires very little or no direction and willingly takes on any task that needs to be done. Often the tasks to be done are initially his ideas. I consider him to be an officer of unlimited potential and I believe he would be an excellent candidate for graduate training. He is an officer that should be kept on the "fast track" in the Medical Service Corps and I most strongly recommend him for promotion to Lieutenant Commander.

FITNESS REPORT
OUTSTANDING LCDR, NC, USN

PROMOTE HER NOW! This officer is absolutely the Best Nurse Corps Officer to have ever worked
for me. LCDR. Xxxx has recently taken over the position of Ambulatory Care Department Head.
She was selected for this position because she is the hardest working, competent, and dedicated
LCDR Nurse Corps officers in my command. In addition, she is also responsible for coordinating
this commands preparation for an upcoming JCAHO Ambulatory Care Focused Survey. Her
selection for these two highly visible and high risk positions tells you how much confidence I
place in this officer. Prior to her selection as Department Head she was the Charge Nurse in the
Emergency Room which is a class III ER at this facility. Some of her note worthy
accomplishments are:

* Capable of establishing manageable Goals and Objectives and reaching them in a timely
fashion.

- As Chairman of the JCAHO preparation committee, she has established an extensive time
line for completion of all preparation efforts. Will include two "mock surveys". She is on
target with her objectives and is dynamic in her leadership of this mixed discipline group.
- Prepared the Hospital self-assessment in preparation for the JCAHO survey.
- Developed, and where necessary revised. policies for the Emergency Room. For example,
she drafted a change governing use of, and dispatch of Ambulances from the ER.
- She provided OJT to the new ER Nurse at nearby Timbucktoo USAF Base Clinic. Almost all
of her procedures that she had in place were "instituted" at the Clinic ER.
- Has met all deadlines for assigned projects. She can be depended upon to get the job
accomplished.

* Committed to Quality Patient Care.

- Implemented the QA occurrence screening program in the Emergency Room, and selected
topics for targeted reviews in the ER. Initiated a "call back log" for ER test results.
- Developed a Cardiac Arrest Flow Sheet for submission to the Special Care Unit Committee
which incorporated new protocols.
- Wrote the QA Nursing Ad Hoc Committee guidelines.
- Has taught the QA program at nursing orientation. She has also attended the Ward Staff
Nurses meetings to answer questions on QA.
- Made major contributions to the Quality Assurance Program at the Naval Station Branch
Clinic following a QA assist visit.

* Professional Development.

- Selected for full time Outservice Training for a Masters Degree in Trauma Nursing at the
University of Maryland. [One of the foremost trauma centers in the world.]
- Made an assist visit to the NAVSURFPAC clinic at Chinhae Korea. She made
recommendations to help that activity provide better quality of care in this remote duty station.
- Taught two ACLS courses and has maintained her instructor status.
- Revised the ER Nurses Orientation and ER Corpsmen Skills Inventory SOPs. Persued a
medication administration certification test for ER corpsman.
- Conducted over 15 CPR drills and provided critiques. In addition, she made a CPR training
video tape with assistance of the Respiratory Therapy Division.
- Developed a Standard Policy Manual for the Nursing Duty Officer.

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LCDR Xxxxx is a team player and is willing to take on any job that will enhance the ability of the command to perform its mission. Her potential for future growth is unlimited and she should be given ample opportunity to excel. I would whole heartedly recommend this fine officer for future billets in nursing administration. She is most strongly recommended for early promotion to the rank of commander.
Passed PRT.

FITNESS REPORT
TYPICAL CDR, MC, USN

I believe that during this reporting period CDR Xxxxx has come into his own as a leader and manager. He is ready for assignment as a Director for Surgical Services! His sustained superior performance, professional knowledge, self-motivation, management skills and leadership improved the operational effectiveness of his department and were crucial in this command accomplishing its mission. His work is comprehensive and accurate. He has a keen sense of personal responsibility for the outstanding quality of his work. He will make the tough decisions without wavering and has uncompromising personal honor and integrity.

* As Department Head he:

o Provides professional medical and managerial leadership for 6 officers, 14 enlisted, and 5 civilian personnel.

o Mature, innovative approach to problem solving has earned him the reputation of "Answer Man" among the staff.

o In addition to own duties as Department Head, has been Acting DSS, and Acting XO.

o Active support in community relations through his support of multiple clinical services professional exchange and staff lecture exchanges.

o As Fleet Medical Laision Officer, has provided prompt access to medical care for the fleet, thereby increasing their operational readiness.

* Supports Quality Health Care:

o A fully credentialed, board certified, active staff member, he is a superior clinician and maintains his patient records with accuracy, promptness, and appropriateness.

o Continued solid support of command Quality Assurance program through his leadership of the medical staff toward improved QA programs and modified records and monitoring methods.

o In addition to his duties as Department Head, he was still able to maintain a schedule of surgery 1 day per week and clinic 3 days per week. He received several letters of appreciation from his patients.

* Professional Development:

o Screened for XO; selected to attend the Senior Medical Department LMET; completed the Senior Officer Course in Military Justice.

o Maintains CME requirements via command and USUHS sponsored lectures, and at own expense attended the American College of Surgeons Meeting when command funds were not available. Achieved over 60 hours of CME.

CDR Xxxxx is a thoughtful, resourceful, tactful, and skillful, leader, a superior medical officer, and a gentleman in the truest sense of the word. He actively supports Navy policies and has passed his PRTs. He is most highly recommended for all professional pays. He has the attributes that will serve him well as a Naval Officer and he should be given the opportunities to demonstrate his readiness for eventual command XO and CO positions. He is highly recommended for promotion to Captain.

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NAVY MEDICAL DEPARTMENT
INTERMEDIATE-LEVEL OFFICER COMPETENCY MODEL
DEPARTMENT HEAD

QUALITY OF CARE GROUP
1. Concern for High Standards
   a. Holds subordinates accountable for substandard performance
   b. Identifies and communicates problems in patient care
   c. Considers patient care in making decisions

RESOURCE MANAGEMENT GROUP
2. Planning and Goal Setting
   a. Sets goals, objectives, or priorities for self and/or unit
   b. Develops a step-by-step plan to accomplish a goal
   c. Anticipates obstacles and makes plans to overcome them
3. Initiative
   a. Creates or improves programs, procedures, or systems
   b. Ensures or expedites implementation of a plan
   c. Assumes additional responsibility with enthusiasm
   d. Independently takes action to solve a problem
4. Persistence
   a. Employs an alternative strategy when the first approach is unsuccessful
   b. Takes repeated actions to overcome an obstacle or solve a problem
   c. Works over an extended period of time to solve a problem
5. Concern for Efficiency
   a. Monitors use of resources
   b. Delegates tasks to the best-qualified person
   c. Evaluates cost/benefit of programs and systems
   d. Ensures efficient use of people, time, and resources

LEADERSHIP AND MANAGEMENT GROUP
6. Concern for Subordinates
   a. Shows concern for the equitable treatment of subordinates
   b. Demonstrates concern for the health and well-being of subordinates
   c. Acts to obtain rewards, resources, or privileges for subordinates
7. Developing Others
   a. Ensures that subordinates have professional training opportunities
   b. Personally provides information, suggestions, or on-the-job training to subordinates
   c. Gives task-related positive or negative feedback to subordinates
   d. Expresses confidence in subordinates' ability to do the job
   e. Encourages subordinates to act on their own
8. Team Building
   a. Develops unit identity, group cohesiveness, or team spirit
   b. Asks for input from the work group
   c. Gets work unit together to discuss issues

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NAVY MEDICAL DEPARTMENT
INTERMEDIATE-LEVEL OFFICER COMPETENCY MODEL
DEPARTMENT HEAD

9   Conflict Resolution
   a.   Takes action to prevent conflict from developing or escalating
   b   Confronts problems directly and reaches decisions
   c.   Exercises self-control in conflict situations

10.   Clear Communication
   a.   Ensures clarity of instructions
   b.   Explains reasons for decisions to ensure understanding
   c.   Informs own staff about work issues
   d.   Maintains channels of communication with other departments
        or units

DIAGNOSTIC CAPABILITIES GROUP
11.   Information Gathering
   a.   Informally gathers information about work unit
   b.   Seeks information from multiple sources to deal with a specific situation
   c   Seeks information directly from key person or source
   d.   Uses an explicit inquiry strategy to diagnose a situation

12.   Interpersonal Assessment
   a.   Understands the needs, interests, agenda of an individual
   b.   Is sensitive to nonverbal behavior
   c.   Identifies factors that contribute to a person's behavior
   d   Interprets the unspoken meaning in a situation
   e.   Acknowledges own strengths or weaknesses
   f.   Learns from past experience

13   Analytical and Conceptual Thinking
   a.   Identifies key issues in a problem
   b   Compares an actual situation with what should ideally happen
   c.   Sees the similarity of a problem to situations previously encountered
   d   Sees parallels between apparently unrelated situations
   e   Systematically considers the advantages and disadvantages of possible actions
   f   Identifies the implications of a particular problem or situation for other
        departments or for the larger system

INFLUENCE GROUP
14   Use of Influence Strategies
   a.   Attempts to persuade others by pointing out positive or negative consequences
   b.   Uses data to influence
   c.   Develops situations to influence others
   d   Markets an idea or proposal by talking to others
   e   Writes for impact
   f.   Influences through others

15   Political Sensitivity
   a.   Demonstrates awareness of the agenda of a group
   b.   Keeps superiors informed, especially on sensitive issues
   c.   Understands the relationship of one's own unit to larger units within the Navy

Enclosure (4)

NAVY MEDICAL DEPARTMENT
INTERMEDIATE-LEVEL OFFICER COMPETENCY MODEL
DEPARTMENT HEAD

16 <u>Concern for Image</u>
  a. Emphasizes the importance of one's role as a leader/manager
  b. Shows concern about the reputation of self, unit, or speciality, within one's professional community

(Taken from NSHS LMET Course)

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SUGGESTED READING

1. Haering, George. *Fitness Report Finesse.* Proceedings, U.S Naval Institute, January 1980, pp 34-38.

2. Drewry, Douglas L. Enlisted Eval & Officer Fitrep Writing Guide. Professional Management Spectrum, Inc., Pensacola, Florida. 1984.

3. Swensen, Charles C. Jr., LCDR, *Where Do You Really Stand?* Proceedings, U.S. Naval Institute, Vol. 113/8/1014. August 1987, pp112-113.

4. Tomeo, Jeffrey A. LT, *The Academy Way.* Proceedings, U S Naval Institute, Vol. 113/8/1014. August 1987, pp117-118.

5. Scott, Thomas P. CAPT (Ret), *The CO's Gouge.* Proceedings, U.S. Naval Institute, Vol. 113/8/1014. August 1987, pp119-121.

6. Mize, David M. LCOL, USMC, *The Answer Is in Hand.* Proceedings, U.S. Naval Institute, Vol. 113/11/1017. November 1987, pp127-131. (pretains primarily to the USMC system but is good reading).

7. NAVMILPERSCOM INSTRUCTION 1611.1 CHANGE TRANSMITTAL 2, dtd. 3 February 1987. Subj: Report on the Fitness of Officers.

Enclosure (5)

From: Commanding Officer
To: All Personnel

Subj: TOTAL QUALITY LEADERSHIP (TQL) IMPLEMENTATION

1. I am certain that many of you have heard of our commitment to Total Quality Leadership
(TQL) at Naval Hospital Charleston. TQL is leadership and management by "everyone."
Someone once said, "No organization is so screwed up that somebody doesn't like it as it
is." People have a tendency to cling desperately to the past. They hang on to what's
familiar, snuggling ever deeper into their comfortable routines to avoid the chilling thought
that they might have to change. Change implies giving up control and having to deal with
uncertainty. However, change is inevitable. Change offers opportunity. Change is difficult.
TQL will be a big change! This isn't something that Navy Medicine decided to do just for
the fun of doing it. TQL is a change for survival of the Medical Department, and it really is
just plain common sense. It is an opportunity for every one of you to shape the future. As
the Navy *downsizes* we will have to find ways to do our jobs better, more efficiently, and
insure quality service and products to those we support. You know the best way to get the
job done. Each of us has a responsibility for ensuring that we provide our "customers," both
internal and *external,* the best service or product that we can. In order for Navy Medicine to
survive in the future as a leader in health care, TQL must affect and involve each and every
one of you. You and your actions will determine how we meet the vision, mission and goals
of this command, in order to shape the future.

2. The following ten premises outline the basic philosophy of TQL. They are the precepts
which result in customer satisfaction. They are the foundation of TQL.

>   1). **People want to do their jobs well.** Self-satisfaction and pride in
> one's performance are the greatest motivators toward continued quality
> improvement. Given a positive and supportive environment, every person will
> do a job well. The result will be increased quality in the services we provide
> to our customers.

>   2). **The person doing a job is likely to be most knowledgeable about
> the best way to do it.** As an individual who works directly with the process,
> you are the subject matter expert and should be recommending changes that
> would better meet the needs of our customers. Along with this empowerment
> to effect change comes responsibility and accountability. These always go
> hand-in-hand. But don't be afraid to contribute; after all, in our career field
> you and I have always had the critical responsibility and accountability for
> patient care.

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3). **Every person wants to feel like a valued contributor.** It is the responsibility of top management to ensure that significant, noteworthy contributions do not go unrewarded. Rewards are not always monetary. Reward and recognition may come as team members celebrate the successful accomplishment of their task. We must also be capable of self reward and the inner satisfaction from doing a job right the first time.

4). **Improving quality leads to higher productivity.** The greatest impediment to increased productivity is *rework* - having to do something again to get it right. With increased emphasis on quality management, the percentage of rework should drop as our productivity rises.

5). **More can be accomplished working as teams than as individuals.** The saying *"The whole is greater than the sum of its parts"* certainly applies in quality management where the *Process Action Team (PAT)* is composed of personnel having *ownership* or knowledge in an area necessary for improvement. The result of the PAT is not the *quick fix* but the change required in the process to prevent further problems.

6) **Adversarial relationships between groups are counter productive and outmoded.** By talking with one another and expressing our needs, we can break down barriers and pull together to reach goals. Re-open lines of communications. Make sure that you say what you believe and that your communication is clearly understood.

7). A **structured problem solving process, using graphical techniques, produces better results than an unstructured process.** Sharpening one's skills in the use of a standardized approach to observation has always been a clearly recognized benefit in technical and research methodologies. We will use the **FOCUS-PDCA** process to standardize our approach to problem solving and increase our success rates in problem resolution. TQL is a data driven system; graphical analysis is the most effective way of communicating that information. All hands will receive training in required TQL techniques.

8). **Quality improvement is EVERYBODY'S job.** Our customers may be *external*, such as our patients in general, or they may be *internal* customers. You are my internal customer, and your coworker, subordinate or the department *next door* are all internal customers to you. We must provide quality service to all of our customers. I am dedicated to the TQL concept, and you will receive my full support. I have already dedicated resources and personnel to support your need to resolve problems and better serve all of our customers.

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9). **Innovation at all levels is the life-blood of an organization.**
Reread premise number 2. The person doing the job is most
knowledgeable not only of actual performance but in innovations toward
improvement of that performance. *We've never done it that way before* is a
phrase that does not fit into total quality improvement nor its leadership.
"Faced with the choice between changing one's mind and proving that
there is no need to do so, almost everybody gets busy on the proof," said
John Kenneth Galbraith. Let's be open minded to new ideas!

10). **What is *acceptable* is always changing.** It may be confusing initially
to think that *the only consistency is change*, but it is so true. To quote
Ashliegh Brilliant." Strangely enough, this is the past that somebody in the
future is longing to go back to." We must constantly reevaluate the needs
and expectations of our customers and adjust our actions accordingly.
Change that can be predicted and planned for makes a smooth transition.

3. We Must Make A Long Term Commitment. TQL is not a *quick fix* for our problems
but a never ending journey toward *Continuous Quality Improvement*. The emphasis must
be on careful review of the process and implementing improvements which are proposed
by those who own and participate in the process. This takes time, but the outcome *is
quality*. Such a long journey implies continual education, training and practice in TQL
methods and techniques.

4. Implementation of TQL has begun! As we progress each of you will be provided
additional information, education, training, and practice to ensure your active
participation as a valued customer and team member. The Executive Steering
Committee has already selected our first *opportunity for improvement* and appointed our
first *Process Action Team (PAT)*. I look forward to imaginative and innovative solutions
and improvements from each of you. After all, you *are* doing the job . . . who better to
tell the rest of us how the job should be done.

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APPENDIX I: MTF VISION, MISSION, GP's, SG's

NAVAL HOSPITAL CHARLESTON VISION STATEMENT

WE WANT TO BE YOUR FIRST CHOICE!

- FOR COMPREHENSIVE AND EFFICIENT CARE
- FOR PERSONAL AND PROFESSIONAL DEVELOPMENT WITH JOB SATISFACTION
- FOR FLEET AND SHORE-BASE MEDICAL SUPPORT AND READINESS
- FOR MEDICAL AND ALLIED HEALTH EDUCATION

PROFESSIONAL DEVELOPMENT

MEDICAL EDUCATION

TQL

COMPREHENSIVE CARE

MEDICAL READINESS

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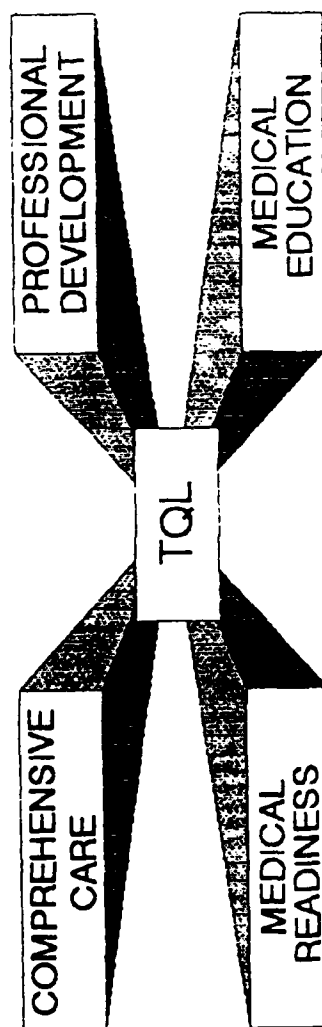
NAVAL HOSPITAL CHARLESTON MISSION STATEMENT

Our mission is to keep the men and women of the Navy, Marine Corps, and other services healthy, and to provide for their families and all in the Charleston area who depend on us for their healthcare needs.

By continually seeking opportunities for improvement, we will:

- Provide all our patients with access to the finest state of the art medical care, delivered with a caring and compassionate attitude.

- Ensure fleet and shore-based commanders consistently receive the best medical care available.

- Empower and challenge our staff to excel in their duties, thus attaining job satisfaction and personal/professional growth for each and every staff member.

- Conduct a Family Practice residency program which will provide the best medical training available.

- Promote wellness and a safe, healthy environment.

ACCESS TO CARE | FLEET SUPPORT | EMPOWER STAFF | FAMILY PRACTICE RESIDENCY | PROMOTE WELLNESS
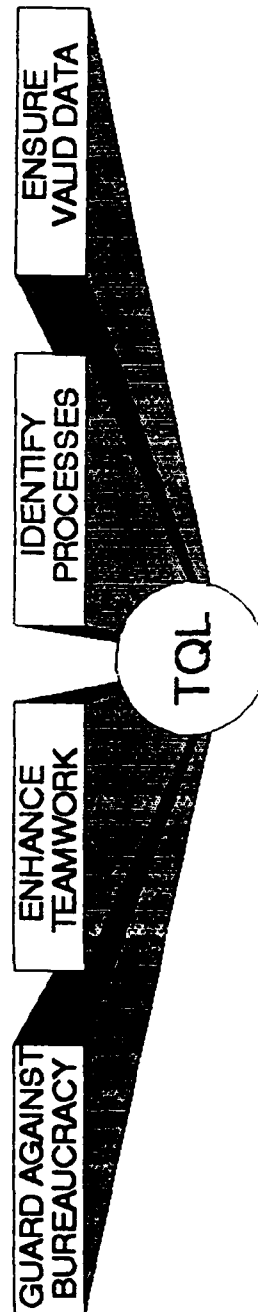
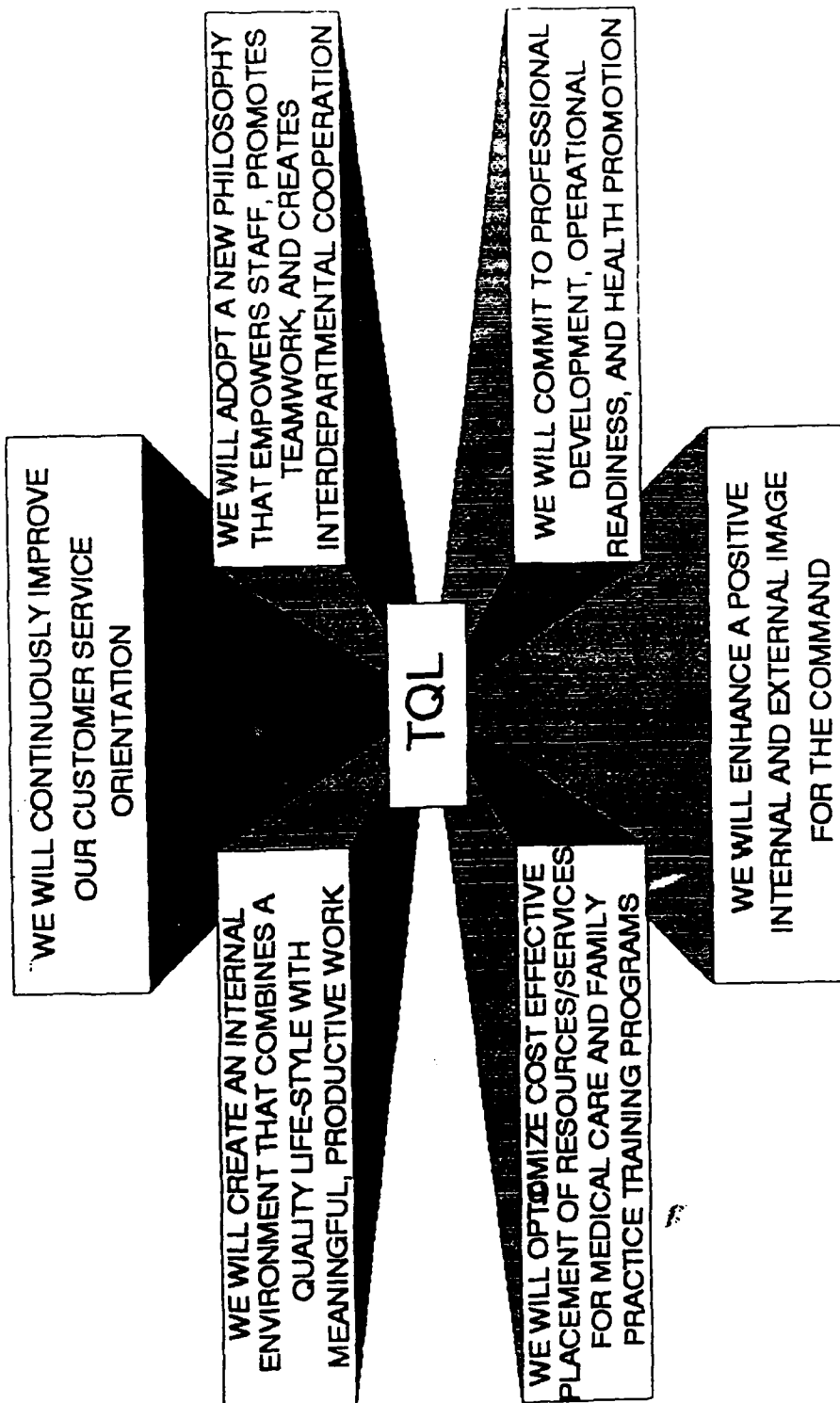TQL

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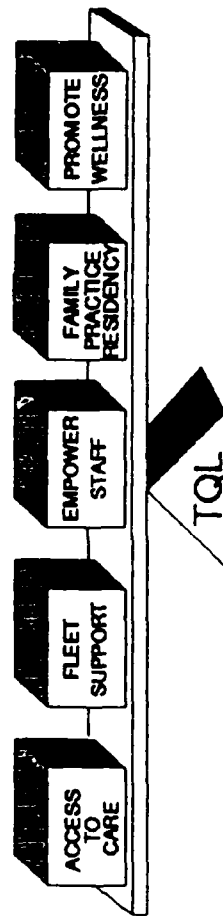
NAVAL HOSPITAL CHARLESTON GUIDING PRINCIPLES

The needs of people will constantly be the primary consideration in all our decision making. These people are our patients, our staff members, Family Practice residents, and the fleet and field commanders to whom we provide medical support.

To maintain this focus, we will:

■ Guard against being bound by an inflexible burearcracy which interferes with meeting the needs of our customers.

■ Enhance a spirit of teamwork which will help to improve communication and eliminate organizational barriers.

■ Identify key processes within the command and strive to make continual improvement a part of our organizational culture.

■ Ensure that we have valid data to justify and support the actions that we take.

GUARD AGAINST BUREAUCRACY

ENHANCE TEAMWORK

IDENTIFY PROCESSES

ENSURE VALID DATA

TQL

NAVAL HOSPITAL CHARLESTON
STRATEGIC GOALS

WE WILL CONTINUOUSLY IMPROVE OUR CUSTOMER SERVICE ORIENTATION

WE WILL ADOPT A NEW PHILOSOPHY THAT EMPOWERS STAFF, PROMOTES TEAMWORK, AND CREATES INTERDEPARTMENTAL COOPERATION

WE WILL COMMIT TO PROFESSIONAL DEVELOPMENT, OPERATIONAL READINESS, AND HEALTH PROMOTION

WE WILL CREATE AN INTERNAL ENVIRONMENT THAT COMBINES A QUALITY LIFE-STYLE WITH MEANINGFUL, PRODUCTIVE WORK

TQL

WE WILL OPTIMIZE COST EFFECTIVE PLACEMENT OF RESOURCES/SERVICES FOR MEDICAL CARE AND FAMILY PRACTICE TRAINING PROGRAMS

WE WILL ENHANCE A POSITIVE INTERNAL AND EXTERNAL IMAGE FOR THE COMMAND

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LIST OF REFERENCES

1. Section 8096, Defense Appropriations Act, FY 1992.

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